THE REPUBLIC OF UGANDA

NATIONAL ALCOHOL CONTROL POLICY

Ministry Of Health

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FOREWORD

The Government of Uganda (GOU) is making every possible effort to improve the health and socio-economic conditions of the people of Uganda in line with the policy of poverty eradication.

The government recognizes the role that alcohol plays in Uganda both in terms of its social and economic contribution and in terms of its significant capacity, when misused, to impose unacceptable costs on individuals and the community as a whole. While alcohol has existed for a long time, science has continued to discover its adverse health, social and economic consequences, some of which interfere with one's personal, or professional life, family and the wider community, as well as national and regional development endeavors.

Apart from the heavy burden of infectious diseases, Uganda is also experiencing an upsurge in the occurrence of Non- Communicable Diseases (NCDs) such as hypertension, cancer, diabetes, mental illness and chronic heart diseases. The evidence in literature on the risk of developing non-communicable diseases as a result of alcohol use is irrefutable. Alcohol can damage nearly every organ in the body and because it is psycho active, it can induce alterations in most of the brain structures and its use contributes to 200 diseases and conditions, including chronic diseases such as alcohol dependence, liver cirrhosis and acute health problems such as injuries.

About 20% of the admissions at Butabika National Referral Hospital are due to alcohol or other drugs. Data from the WHO commissioned 2014 nation-wide non-communicable risk factor survey (STEPS) showed that 25.9% men and

14.3% women in Uganda were heavy alcohol users. The 2014 Global Status Report on alcohol also indicated a per capita consumption of 9.8 litres compared to 6.0 litres in the African region and a prevalence of 5,8% Alcohol use disorders (AUDS) in the Uganda population.

Alcohol consumption is associated with high risk behaviors including unsafe sex and use of other psycho active substances and tends to be associated with dependence on other drugs and sexually transmitted infections.

Alcohol is used in many societies for social economic reasons. However, if unregulated, alcohol causes unacceptable costs to the individual and community as a whole, which outweigh its perceived benefits.

The Government of Uganda recognizes that for this policy to be effective and sustainable, cooperation and creative partnerships across all sectors including Health, Gender, Labor and Social Development, Justice, Law and Order, Local Governments, Education, Trade, Industry, and co-operatives, Finance and Civil Society Organizations among others are required. Responsibility for the successful implementation of this Policy should be shared by all Ugandans.

On 25th May 2005, the World Health Assembly adopted a resolution to adopt the Global Strategy to reduce harmful use of Alcohol which lists policy options and recommendations for addressing harmful use of alcohol. Uganda also adopted the recommendation of the high level meeting on NCDs held in New York on 19th June 2014 which recognized alcohol as a major risk factor for NCDs among other health problems and urged countries to reduce alcohol use to address NCDs.

More recently, the United Nations Sustainable Development Goals (SDGs), in particular Goal 3 – Good Health and Well Being, has a target of strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. Uganda has formulated a policy that will guide actions by all relevant stakeholders to reduce harmful use of alcohol.

Dr. Jane Ruth Aceng Ocero
Hon. Minister of Health

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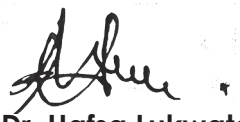

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WORKING DEFINITIONS

The following terms are peculiar to the subject matter of this policy:

Abuse

- Use of alcoholic beverages in excess, either on individual occasions (binge drinking) or as a regular practice.
  Or
- Dysfunctional use of alcohol.

Adult

- A person who is twenty one years and above.

Alcoholic Beverage

- Liquid that contains alcohol and is intended for drinking.

Alcohol Availability

Refers to access to alcohol.

- This may be physical availability, such as when, where and under what conditions alcohol may be legally purchased, or

- It may also be economic availability, the extent to which consumers can afford to purchase alcohol.

Dependence / addiction

- A clinical condition clearly defined by specific diagnostic criteria. It is not interchangeable with

"abuse"; not all those who abuse alcohol are or become dependent.

- The dependence/addiction syndrome is a cluster of behavioral, cognitive and physiological symptoms that indicate that a person has impaired control of psychoactive substance use and continues use of the substance despite experiencing adverse consequences.

- Physical dependence / addiction on alcohol refers to the extent that stopping alcohol use will bring on withdrawal symptoms.

Drinking Patterns

Patterns describe numerous ways of drinking that include:

- How much people drink, particularly on a given occasion and how many of these occasions is the drinking heavy

- Where drinking takes place, whether at home, in bars and restaurants, or in other public venues

- When people drink, whether with meals, at gatherings, and how drinking is spread out over time at one sitting

- Those with whom people drink: family, friends, peers, colleagues or others

- Types of alcohol consumed, including licensed commercially produced alcohol of known quality, illicitly produced alcohol, and possibly toxic and adulterated drinks

Harmful use of alcohol

Harmful use of alcohol is defined as a pattern of alcohol use that is causing damage to health, and the damage may be physical (as in cases of liver cirrhosis) or mental (as in cases of depressive episodes) secondary to heavy consumption of alcohol.

Intoxication

- A condition that follows the use of alcohol resulting in disturbances in the level of consciousness, ability to think rationally, sense of judgment, mood or behaviour functions and responses.

- When the quantity of alcohol consumed exceeds the individual's tolerance for it and produces behavioural or physical abnormalities.

Litre of Pure Alcohol

- This is an international description that refers to the alcohol content (as 100% ethanol) per litre measured. Every measure of alcohol unit has a proportion of ethanol in it and a litre is taken as the standard measure to establish this.

Minor

- A person below the age of 21 years

Social harm

- Harm associated with the misuse of alcohol which impacts at individual, family, community and societal level. These may include harm associated

with criminality, domestic violence, health related problems, insecurity of social welfare, economic losses, absenteeism and diminished work performance.

Underage drinking

- Consumption of alcohol by people below the legally prescribed age limit. In this policy the age limit is 21 years.

1.0 INTRODUCTION

Alcohol use is embedded in many cultures across the world with an estimated 2 billion people drinking alcohol globally (WHO, 2018). In recent years, there has been increased availability and accessibility of alcoholic beverages, leading to changes in drinking patterns across the globe.

However, alcohol consumption is one of the major risk factors for chronic diseases and injuries accounting for 5.3% (3 million people) of all deaths globally (WHO, 2018). Evidence shows that harmful use of alcohol is associated with a wide range of health, economic and social consequences that negatively impact development. These consequences include diseases, violence against women and children, neglect of children, crime, accidents, victimization of vulnerable groups, poverty and reduced productivity.

The harmful use of alcohol has been identified as the third largest contributor to the global burden of disease after unsafe sex and childhood underweight (WHO, 2011). According to the Global Status Report on Alcohol and Health, 5.1% of the global burden of disease and injury as measured in Disability Adjusted Life Years (DALYs) was attributed to alcohol (WHO, 2018). Additionally, alcohol is a causal factor in more than 200 types of diseases and injuries with neuropsychiatric conditions (such as alcohol dependence, psychoses and depression) and unintentional injuries such as; road traffic crashes, burns, drowning and falls accounting for most DALYs lost.

Alcohol causes approximately 3 million deaths annually which are more than those attributed to diseases such as; Tuberculosis, HIV/AIDS, and diabetes (WHO, 2018). The young are particularly affected by alcohol-related harm with 13.5% of the total death among persons aged 20-29

years attributable to alcohol. Alcohol is also the leading risk factor for death in males aged 15-59 (WHO, 2014b).

Alcohol is linked to Human Immune Virus (HIV) and Tuberculosis (TB) acquisition. For instance, active TB is 3 times more likely among people who drink more than 40g of alcohol/day (Patra et al., 2014). Additionally, people who use alcohol have been found to be 3-4 times more likely to be non-adherent to their TB treatment (Rehm et al., 2009). This in turn can lead to the development of drug resistance and subsequently affect disease progression and mortality .

Harmful use of alcohol is associated with many other dangers which outweigh the benefits. Studies in Uganda have shown a strong connection between harmful use of alcohol and poverty (Lwanga-Ntale, 2007), violence (Tumwesigye et al., 2012b) road traffic injuries (Tumwesigye et al., 2016), and a range of communicable diseases (Ocama et al., 2008) and non-communicable diseases such as mental illness (Naamara and Muhwezi, 2014), liver and heart disease (Schwartz et al., 2014);. The costs of harmful use of alcohol to society are also substantial. Families often bear the burden of the social impacts of harmful use of alcohol in terms of domestic violence and deprivation. Alcohol use is strongly associated with boda boda injuries yet the cost of treating a victim of boda boda injury was estimated to be as high as USD 369 (Galukande et al., 2009). Such situations require comprehensive policy measures to reduce alcohol related harm, not just for drinkers but also to protect those individuals, and groups who are at risk of being negatively affected (Ramstedt et al., 2015).

The WHO, at its 58th World Health Assembly in May 2005, adopted resolution WHA 58.26 which requested member states, Inter governmental organizations, health professionals, non governmental organizations and other stakeholders to promote the implementation of effective policies and programs to reduce the harmful use of alcohol (Sambo and WHO, 2014).

The 3rd East African Conference on Alcohol noted that alcohol consumption presented current and future threats to both public health and economic development in the region and the need to promote alcohol policy measures that are evidence based (WHO, 2012). The 7th Parliament of Uganda, in July 2005, also expressed concern on the unacceptably high levels of alcohol consumption and requested the Ministry of Health to develop a policy in consultation with other sectors and institutions (GOU et al., 2011). In 2015 the cabinet appointed a subcommittee to work with a multi-sectoral technical team that reviewed the situation of alcohol and drug abuse, gambling and prostitution and made recommendations for national interventions to address the problems

The Government of Uganda recognizes that it has a responsibility to protect the entire society (particularly young and other vulnerable people) against the impacts of harmful use of alcohol and will use the proven cost-effective and affordable interventions for mitigating harmful use of alcohol. This policy supports efforts by individuals, families, communities and institutions to prevent harmful use of alcohol.

1.1 POVERTY

The Uganda participatory poverty assessment report showed that Alcohol consumption was second most cited cause of poverty (MOFPED, 2002)

1.2 ALCOHOL AND SUSTAINABLE DEVELOPMENT GOALS (SDGs)

Alcohol consumption undermines commitments to achieve 13 of the 17 United Nations Sustainable Development Goals (SDGs), impacting on a range of health-related indicators, such as child health, infectious diseases and road injuries as well as a broader range of indicators related to economic

and social development, environment and equality. (WHO, 2018).

This policy will contribute towards achievement of several alcohol related SDG targets including 3.4 on reduction of premature mortality due to non- communicable diseases by one-third by 2030.

2.0 SITUATIONAL ANALYSIS

Introduction:

Africa as a region has a higher per capita alcohol consumption among current drinkers than the world average (40.0 vs 32.8 grams/day) (WHO, 2018). In most parts of Africa problems associated with alcohol consumption are on the increase (Degenhardt et al., 2018). The most characteristic pattern of alcohol consumption in the region was reported to involve binge and episodic drinking (Ferreira-Borges et al., 2017). Data from the Global Burden of Disease estimates revealed that in Africa, 4.1% of all DALYS lost could be attributed to alcohol use (WHO, 2018).

In Uganda, the recorded annual alcohol per capita consumption in litres of pure alcohol is 9.5 litres with the consumption among drinkers being higher at 26.0 litres of pure alcohol per capita (WHO, 2018). According to the 2014 nationwide Stepwise approach to surveillance on non-communicable diseases (STEPS NCD) risk factor survey, 40.1% of men and 17.9% of women (overall 28.9%) adults in Uganda aged 18 - 69 years were current alcohol users while 9.1% had an alcohol use disorder (Kabwama et al., 2016). Although the proportion of women who use alcohol is lower than that of men, the negative effect of alcohol on mothers especially those pregnant is well documented. This includes risk of low birth weight babies and babies with fetal alcohol syndrome which can have lifelong negative consequences (Joseph et al., 2020).

Illegal production of alcohol in Uganda makes it very accessible to vulnerable populations such as, orphans, street children, refugees or those children living in camps for the internally displaced (Swahn et al., 2017, Bapolisi et al., 2020). A recent study among out of school youth in Kampala showed that 30% of teenagers consume alcohol and 90% of teenage drinkers are binge drinkers (Swahn

et al., 2017). Worrying trends have been observed in schools with up to 70% of secondary school going youth using alcohol with age of first use as low as 8 years (Abbo et al., 2016). Binge drinking during public events and parties and promotions are the commonest drinking features for young people(UYDEL, 2008). Drinking patterns and general risk-taking behavior among the youth places them at considerable risk of harm.

In Uganda, alcohol production and consumption is a legal and culturally accepted practice. The legally manufactured beers and spirits account for 48% of the alcohol beverage market share (Sekimpi et al., 2015). The rest of alcohol is from the informal sector. While spirits are packaged in small volumes, majority of local brew is communally shared from pots/calabashes making it difficult to quantify individual alcohol intake. The informal sector is not monitored by Uganda National Bureau of Standards (UNBS) and the alcohol content is not known, making it difficult to establish its safety (Sekimpi et al., 2015).

General negative consequences of alcohol consumption

Alcohol is associated with a multitude of negative social and economic consequences and this is quite prevalent in Uganda. A secondary analysis of data in 26 countries in 2010 found that Uganda had the highest prevalence of negative consequences of alcohol consumption. These included personal and social consequences (Graham et al., 2011).

Mortality and alcohol:

There are multiple mechanisms through which alcohol use affects health including the adverse effects it causes on organs and tissues, acute intoxication leading to injuries or poisoning, the dependent drinking leading to impairments and potentially self- harm or violence; all of which can lead to death (WHO, 2018).

It is estimated that 5% of the mortality in Uganda is directly attributed to alcohol consumption (WHO, 2014a). At 26.3 road traffic related deaths per 10,000 inhabitants, Uganda is among the 10 countries with the worst road safety in Africa (Jacobs et al., 2000, WHO, 2018) and alcohol contributes 45.7% of death rates resulting from road traffic accidents (WHO, 2014a).

Alcohol consumption is associated with suicidal ideation, violence and premature death. A study carried out among rural students in Uganda attributed the prevalent suicidal ideation to alcohol consumption (Rudatsikira et al., 2007). Several studies indicate a relationship between alcohol and homicides (Swatt and He, 2006) and this is clearly evident in Uganda (Mushanga, 2013). Uganda Alcohol Policy Alliance reports of 2008 and 2010 show that 329 people died after consuming adulterated alcohol (UAPA, 2014)

Alcohol, and Gender Based violence.

Alcohol consumption affects reasoning, rational-problem solving and impulse control so that the likelihood of violence is increased after consumption (Bellis et al., 2008)). There is a high level of domestic violence in rural areas and it has been linked to alcohol consumption and perceived risk of HIV. Alcohol use has also been associated with intimate partner violence and sexual coercion (Tumwesigye et al., 2012b). A study by Koenig et al 2003 showed that approximately one in three women living in rural Uganda reported being physically threatened or assaulted by their current partner. The findings from the study suggest direct links between the risk of domestic violence and alcohol consumption and women's perceived risk of contracting HIV from their partners (Koenig et al., 2003). Results from several small-scale studies have shown that alcohol consumption disrupts marriage and family (Tumwesigye and Kasirye, 2005).

In families, harmful use of alcohol leads to disharmony and disintegration. People with a habit of harmful use of alcohol are more frequently divorced or separated than those without the habit (Tumwesigye and Kasirye, 2005).

Alcohol use, risky sexual behavior, HIV and Tuberculosis infection:

Many studies have shown that infection with HIV increases significantly with alcohol use. Taking alcohol is associated with having two or more sexual partners (Tumwesigye et al., 2012a). The likelihood of getting infected with HIV when one of the partners has taken alcohol before sex is 1.67 times higher among men and 1.40 times higher among women compared with neither partner taking alcohol (Zablotska et al., 2006). Alcohol consumption is associated with an increased risk of TB acquisition, as well as poor antiretroviral therapy (ART) and TB treatment adherence, which in turn affects disease progression and mortality (Kuznetsov, 2014). When compared with people who did not drink alcohol, people who consumed alcohol during treatment had a significantly higher chance of missing 18 or more intensive-phase doses of TB treatment regimen and hence unsuccessful outcomes (Duraisamy et al., 2014)

Alcohol and Mental illness:

Alcohol use is associated with a range of mental illnesses including; mood, anxiety and psychotic disorders. In Uganda, about forty percent of mental health patients in Butabika National Referral Hospital have alcohol related problems (Lule, 2009). Another study at the Butabika National Referral Mental Hospital found that 84 out of 127 (66%) patients who had substance abuse disorders had co-existent mental illnesses. The most commonly abused drug was alcohol (42%) (Awuzu et al., 2014)

Alcohol and the workplace:

A study carried out in Kampala among the police force showed that AUDs were significantly associated with lack of job satisfaction, poor health, problems in implementing personal plans, disciplinary problems, inability to save from personal earnings, debts, and absenteeism from work (Ovuga and Madrama, 2006). In an alcohol control study in the workplace project, it was observed that harmful use of alcohol was causing absenteeism, accidents and injuries among workers, as well as domestic violence and sometimes family break-ups among workers' families (UNACOH, 2014)

Though the WHO and the International Labour Organization (ILO) address the issue of health promotion in the workplace, one of the challenges to this is alcohol abuse in the workplace. ILO has developed the SOLVE Programme: Integrating Health promotion into Occupational Safety and Health (OSH) Policies. This programme includes controlling factors adverse to health such as alcohol, drugs and tobacco abuse, HIV/AIDS, violence and economic and psychosocial stress (Barry, 2019, ILO, 2016). Uganda is yet to roll out the ILO SOLVE program officially but the Occupational Safety and Health (OSH) Department in Ministry of Gender, Labour and Social Development is actively promoting SOLVE in available fora.

Intervention and treatment of alcohol related problems:

A number of prevention, treatment and control initiatives have been undertaken to mitigate alcohol related problems. The Alcohol and Drug Unit (ADU) at Butabika National Referral Hospital provides outpatient and inpatient treatment services for persons with alcohol and substance use disorders. A review of patient files in the unit for a period of three years (from October 2012 - October 2015), revealed that 73% of service users were as a result of alcohol use disorders (Mugisha and Mutamba, 2015).

The data from the Health Management and Information system records at Butabika hospital for the period January to December 2015 shows that on average, 60 patients were treated for AUDs every month and more than 90% were males.

Several other private organisations offer treatment and rehabilitation to people with alcohol related problems. Private initiatives have an estimated bed capacity of 170 patients but it is not possible to establish the number of the people they treat every year. However, considering that the estimated number of people with Alcohol Use disorders in Uganda is estimated to be 893,200, these services are grossly inadequate and are affected by other general challenges in the mental health sector.(Kalema et al., 2017)

Other initiatives include; the global strategy for reduction of harmful use, research especially through academic institutions, sensitization by various actors and arresting drunk drivers.

Principles of the NACP

In agreement with the global strategy for reduction of harmful use of alcohol (WHO, 2010), this policy is based on 11 fundamental priorities. These are: -

- Leadership, Awareness and commitment
- Health Services response
- Community action
- Drink-driving policy and counter measures:
- Alcohol and the work place
- Patterns and availability

- Marketing of alcoholic beverages
- Reducing public health impact of illicit and informally produced alcohol
- Protection of minors
- Pricing
- Intoxication

Leadership, awareness and commitment

Countries with dedicated leadership for control of alcohol such as Thailand and Kenya have been more effective in implementation of alcohol policies, strategies and plans than those that do not have. In Kenya, the National Authority for Campaign against Alcohol and Drug Abuse (NACADA) was established after enactment of the NACADA Act 2012. NACADA coordinates all stakeholders in activities regarding the control of drug and alcohol abuse (Warui, 2016).

In Uganda, Alcohol control programs are coordinated by the division of Mental Health and control of substance abuse at the Ministry of Health. Initiatives to mitigate harmful use of alcohol exist in some government institutions but there is no coordination mechanism for a common agenda. The Ministry of Trade, Industries and Cooperatives has the mandate for controlling the production, marketing and sale of alcohol but it is incapacitated due to the outdated nature of the alcohol control laws and the fact that the mechanisms in place to control the harmful use of alcohol are inadequate. There is need for a national multi-sectoral coordination mechanism to coordinate all stakeholders including but not limited to academia, civil society, and government agencies. Uganda can emulate other countries such as Thailand that have earmarked proportion of alcohol tax dedicated to alcohol control to ensure adequate resources for the multi-sectoral approach.

Health Services response

The Global Status Report on Alcohol and Health reported a 7.1% prevalence of alcohol use disorders among Ugandans compared to 3.7% in the WHO African region (WHO, 2018). Although a wide range of public health-oriented strategies to prevent and treat AUDs is essential, Uganda's health sector is not adequately equipped to handle the challenge. Patients with alcohol use problems are managed in primary health care facilities where the bulk of health professionals lack sufficient skills to diagnose and treat persons with alcohol use disorders and yet specialized treatment and rehabilitation centers are few and ill-equipped to manage all alcohol abuse patients (Kalema et al., 2015). A case in point is the evident lack of pharmacotherapy and psychosocial interventions among their services (Kalema et al., 2017).

Alcohol is a causal factor in 60 types of diseases and injuries and a component cause in 200 others (WHO, 2018). Alcohol is also associated with adverse social consequences that include; violence, child neglect and abuse, absenteeism at the workplaces and more (WHO, 2018). Despite this burden, there are no policies to promote an integrated response. There is an urgent need for strengthening the management of AUDs across the health service spectrum to include relevant medicines on the essential medicines list as well as psychosocial interventions. Alongside treatment of AUDs, it is necessary to establish an integrated monitoring and reporting structure for morbidity and mortality of alcohol related cases.

Community action

Alcohol is commonly used at social events such as sporting and cultural ceremonies. There is a general acceptance of alcohol use in Uganda inspite of its documented harm. There are few Civil Society Organizations (CSO) involved

in mitigation of alcohol harm with limited collaboration among themselves and with the government sector. Some communities have enacted by-laws, ordinances and regulations to control harmful use of alcohol at local levels (UAPA, 2018) and these should be replicated in other areas. Empirical studies show that religious and cultural leaders can promote and prevent alcohol use at the same time (Kalema et al., 2016). Therefore, the role of religious and cultural leaders in the prevention of harmful use of alcohol has to be explored (Tumwesigye et al., 2013).

Drink driving policy and counter measures:

According to WHO, it is estimated that 5–35% of all road deaths are alcohol-related (WHO, 2018). There were 12,805 traffic accidents in 2018; out of which 111 accidents were caused by driving under the influence of alcohol most of which were fatal. Additionally, alcohol was among the causes of marine accidents resulting into drowning (UPF, 2019).

The Traffic Road and Safety Act (TRSA), 1998 CAP 361 Sections 111 and 112 prohibits driving while under the influence of alcohol, driving after consuming alcohol beyond the prescribed limit, and inducing or enticing a driver or person in charge of a motor vehicle to drink any intoxicating liquor (ULII, 2021). Any person driving above 35mg per liter is deemed to be driving under the influence of alcohol. When a driver's Blood Alcohol Content (BAC) is 0.25mls he/she is charged or receipted with an express penalty scheme of Ushs200,000 (USD 70) payable to the bank and if the person fails to pay, the car is impounded and the person is taken to police and is charged in courts of law. Implementation of the TRSA has had some effect but largely limited by irregular and inconsistent enforcement.

Patterns and availability

Alcohol consumption level in Uganda is 9.5 litres per capita and the prevalence of heavy episodic drinking is 28% (WHO, 2019). The per capita consumption is higher among men (16.7 litres) than women (3.0 litres). There was an increase in per capita consumption from 14.4 litres in 2014 to 16.7 litres among men in 2018 (WHO, 2019) which translates to 16% increase in just four years. Studies in the Alcohol and Drug Unit at Butabika and Hope and Beyond Rehabilitation Centre reported that 75% of people reporting for treatment of AUD were aged between 16 and 35 years compared to the Belgians were the biggest percentage of people in rehabilitation centres was 50 years and above (Kalema et al., 2019).

Evidence shows that alcohol is available at all shopping outlets, ranging from retail shops, supermarkets, bars and in some homes. The Liquor Act limits drinking up to 10.00 pm for bars and up to 1.00 am for night clubs, but it's not enforced as alcohol is served at all times of day and night (Tumwesigye et al., 2015). Whereas the packaging of alcohol in small volume polythene sachets was outlawed in 2017, the problem of widespread use of alcohol has persisted since alcohol is now being produced and packaged in bottles as small as 200mls (Otim et al., 2019).

Marketing of alcoholic beverages

Marketing of alcoholic beverages is largely unregulated; there's aggressive media advertising that clearly exposes the youth and other vulnerable members of the population to alcohol.

Alcohol is widely available all over the country due to the largely uncontrolled production, marketing and sale. Alcohol marketing in Uganda is marked with numerous alcohol posters and billboards and is largely self-monitored

by the industry which has few, if any, restrictions (Swahn et al., 2016). Alcohol marketing also takes the form of sponsorship for events such as education, sports and health. It is particularly troubling that youth receive free alcohol as part of alcohol promotion (UYDEL, 2008). The density of outlets, location and opening hours and days of sale are unregulated (Tumwesigye et al., 2015).

The Liquor Act of 1960, Cap. 93 regulates the manufacture and sale of liquor and provides for licensing of traders; sale of permits; and premises for the manufacture and sale of liquor.

The use of direct or indirect incentives that encourage the purchase of alcohol products (sales promotion) is prohibited. Enforcement of the Act is through the Alcohol Licensing Board (ALB), a body that is mandated to provide licenses (Busiku, 2015). The existing weak and outdated regulatory framework necessitates updated policy interventions by the government for effective marketing of alcoholic beverages in Uganda

Reducing public health impact of illicit and informally produced alcohol

Availability of alcohol refers to both recorded and unrecorded alcohol consumption. Unrecorded consumption refers to home brewed beverages, travelers' imports, smuggling, surrogate alcohol and drinks with an alcohol content that is below the legal definition of alcohol. In spite of the devastating risk that informal alcohol poses to the citizens, it is widely prevalent with some studies putting it as high as 89% of the total alcohol produced and consumed in Uganda (Sserunjogi et al., 2018). Between 2008 and 2010, 329 people were reportedly killed after consuming adulterated alcohol (UAPA, 2014). Informal alcohol causes huge financial losses to the country and is also associated with specific problems such as unsafe sexual practices,

diarrhea, organ system damage, trauma, gender-based and domestic violence, depression, child abuse and neglect, and diversion of funds from food and other family expenses in the community (Adelekan et al., 2008). To reduce the public health impact of illicit and informally produced alcohol, WHO recommends good scientific, technical and institutional capacity for the planning and implementation of appropriate national measures (WHO, 2018).

Protection of minors

Over 50% of Uganda's population is constituted by young people of 18 years and below (UBOS, 2017). There is deep concern about the consumption of alcohol by minors with reports of drinking as early as 8 years (Abbo et al., 2016). A survey of 2,502 secondary school students aged 12-24 in 2016 found that 23.3% had drank alcohol in previous 12 months. A more recent study by Swahn in Kampala revealed that 30% of teenagers drink while 90% of teenage drinkers are indeed hazardous drinkers (Swahn et al., 2017). Abbo et al., 2016 found out that 70% of secondary school students had ever used alcohol and substances (Abbo et al., 2016). The high units of alcohol consumption combined with underage consumption makes the population vulnerable to several alcohol related problems (Swahn et al., 2013).

The legal age limit for the purchase of alcohol in Uganda is 18 years. However, experiences from other countries using the age limit applies for all kinds of beverages with some setting age limit for purchaser at 21 years of age. Young people are restricted from purchase of alcohol using different ways including local council by-laws and parental guidance in homes. Community policing has made a difference in some local councils. These minors are taken to Children and Family Protection Unit of police stations for counseling. Some NGOs have come up to counsel such children. Some establishments make requests for identity

cards to discourage consumption of alcohol among the underage but this has been grossly neglected by many sellers (UYDEL, 2008).

Since the alcohol industry targets young people (Rehm et al., 2006), specific measures should be undertaken to prevent early use of alcohol among teenagers and provide for treatment and rehabilitation needs for those who are affected.

Pricing and Tax measures

In Uganda, alcohol is very cheap making it widely available. Although pricing policies are known to reduce harmful use of alcohol, government interventions to control prices of alcohol are inadequate. In Uganda expenditure on alcohol was estimated at USD 1,521 per capita in 2012 yet average income was USD 600. The expenditure was highest in East Africa while the income was second lowest (Healthbridge, 2019). Absence of a price regulation mechanism in Uganda has led to exploitation of the public and loss of revenue but above all increased consumption of alcohol. There is overwhelming evidence to show that taxation policies are a highly effective strategy for alcohol related harm reduction (WHO, 2020)

Poor taxation systems that do not consider inflation and the health costs alcohol imposes on government are not effective in reducing alcohol consumption.

3.0 RATIONALE

Evidence indicates that Uganda has a high consumption rate of alcohol including both formal and informal alcohol. Recent studies indicate an increase in prevalence of alcohol related health and social problems such as gender based violence and drink-driving. Research unequivocally shows alcohol use as a risk factor for communicable and non-communicable diseases

Interventions to address concerns related to production, sale, consumption, regulation and the negative health impacts of alcohol are fragmented and ineffective in addressing the problem.

Some provisions of the current Enguli Act of 1964 are obsolete. The Enguli Act 1964 is limited to regulation of sale, possession of and dealing in local brew. Furthermore, the Enguli Act relies on defunct licensing boards to oversee its implementation and its enforcement. The Act does not have standard and quality specifications for local brew and therefore does not protect the general populace from adulterated and dangerous alcohol that may be fatal.

The Liquor Act of 1969 is more comprehensive than the Enguli Act but still falls short of being sufficient. It regulates the manufacture, consumption and sale of liquor including payment of fees, licensing of sale and premises for liquor dealers, plus penalties for offences. However, it does not address pricing, surveillance, monitoring and research on alcohol. It prohibits sale of alcohol to minors for their own consumption but allows sale to minors on behalf of adults which potentially exposes minors to alcohol use. In addition, the penalties stipulated in the Act are not punitive enough and therefore, not deterrent. For example, the fine for sale of liquor to a minor is a meagre 500 Uganda shillings.

The Potable Spirits Act Cap 97 of 1965 prohibits pricing of spirits based on alcoholic concentration. This Act lacks clarity on the specifications of formulae for increasing the concentration and additives of portable spirits and has serious gaps in its enforcement.

The Traffic and Road Safety Act of 1998 aims to prevent driving under the influence of alcohol. According to the law, drunk driving carries stiff penalties and provides for conducting of laboratory tests to ascertain proportion of alcohol in the blood of the offender. It is a good deterrent to drunk driving but is limited to that.

The Uganda National Bureau of Standards (UNBS) Act 1989 Cap.327 specifies standards for hygiene, manufacturing and manufacturing premises, packaging, labelling for persons involved in handling alcohol and used equipment. However, it does not stipulate standards for informal liquor which is more widely consumed.

There is need for a comprehensive policy to guide the development of a regulatory framework to address the priority interventions for ensuring safe production, sale, consumption of alcohol, plus regulation and management of alcohol related problems and conditions.

Policy Context

The national alcohol control policy has been developed following broad consultations with key government sectors, regulatory and other agencies and civil society organizations. It provides a framework within which government of Uganda, in association with other key stakeholders, shall develop targeted alcohol control interventions in the best interest of all Ugandans.

Furthermore, the policy is premised on the context of the Sustainable Development Goals 2015; Health Sector

Development Plan 2015/2016-2019/2020, Uganda Vision 2040; Poverty Eradication Action Plan (PEAP); Enguli Act 1964 Cap 86; the Liquor Act Cap 93; National Health Policy (2010), Global Strategy to reduce the harmful use of alcohol 2010 and other related legal instruments such as; Portable Spirits Act Cap 97; Traffic Road and Safety Act (TRSA), 1998 Cap 361; Uganda National Bureau of Standards (UNBS) Act, 1989 Cap 327; Food and Drugs Act, Cap 278; The Trade (Licensing) Act 1969, Cap 101; The Shop Hours Act, Cap 99; VAT Act, Cap 349; Income Tax Act, Cap 340; Exercise Tariff Act, Cap 337; Customs Tariff Act (338); and Local Governments By-laws. An alcohol and drugs master plan will be drafted to operationalize the implementation of this policy.

4.0 OVERVIEW OF THE PROPOSED POLICY

4.1 Vision

A country free of harmful use of alcohol and its consequences

4.2 Mission

To prevent and address alcohol related harm to individuals, families, communities and society.

4.3 Objectives

The policy has the following objectives:

1. To establish a coordinated multi-sectoral framework for action to reduce harmful use of alcohol and its consequences.

2. To strengthen regulation on production, availability, marketing and pricing of alcohol so as to protect vulnerable people from its harmful use of alcohol.

3. To build capacity of government and other stakeholders for prevention, treatment and management of alcohol use related problems.

4. To reduce the negative effects and impact of illicit and informally produced alcohol.

5. To establish and improve research, monitoring, evaluation, surveillance and dissemination of information on alcohol use in Uganda.

5.0 GUIDING PRINCIPLES

The guiding principles of this Policy are: -

1. Human rights. The policy will ensure the right to health and safe environment. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.

2. Evidence -based. The policy will be based on evidence informed approaches to reduce harmful use of alcohol.

3. Protection of vulnerable groups. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages. The policy will emphasize the protection of vulnerable groups such as children, adolescents, and people with alcohol use addiction from promotion of alcoholic beverages and the groups will be availed with correct information on effects of alcohol.

4. Universal coverage/equity. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.

5. Multi-sectoral cooperation and community involvement. The policy will be implemented through a multi-sectoral and community involvement approach.

PRIORITY AREA 1: LEADERSHIP, AWARENESS AND COMMITMENT

Policy issue

There is need for a dedicated institution for multi-sectoral approach for control of alcohol. This would be in position to raise adequate funds and coordinate inter-sectoral policies and action plans for effective, sustainable implementation and evaluation of alcohol control.

Policy response

To establish/strengthen and promote strong leadership, awareness, political will and commitment for prevention of harmful use of alcohol.

Policy strategies

The government shall;-

a) Establish a National Alcohol Control Committee (NACC) to be responsible for overall implementation of alcohol control policies, strategies and plans

b) Establish budget lines within respective departments and agencies to meet the capital and recurrent expenditures regarding the overall implementation of alcohol policies, strategies and plans.

c) Develop or strengthen existing, comprehensive national and local government strategies, plans of action and activities to reduce the harmful use of alcohol.

d) Coordinate alcohol control strategies with those who work in other relevant sectors, including cooperation between different levels of governments, and with

other relevant health-sector strategies and plans (such as road safety, HIV/ AIDS, tuberculosis, violence and injuries, NCDs, maternal and child health, education, gender, trade, security, e.t.c).

e) Ensure broad access to information and effective education and public awareness programmes among all levels of society about the full range of alcohol-related harm experienced in the Uganda and the need for, and existence of, effective preventive measures.

f) Raise awareness of harm to others and among vulnerable groups caused by drinking, avoiding stigmatization and actively discouraging discrimination against affected groups and individuals.

g) Formulate guidelines and regulations to protect alcohol control policies from commercial and other vested interest of the Alcohol Industry.

PRIORITY AREA 2: HEALTH SERVICES RESPONSE

Policy issue

Health services are central to tackling harm at the individual level among those with alcohol use disorders and other health conditions caused by harmful use of alcohol. Health services should provide prevention and treatment interventions to individuals and families at risk of or affected by alcohol-use disorder and associated conditions. Unfortunately, many health professionals in Uganda currently lack the resources, support and ongoing information and training required to effectively assess and treat patients with alcohol issues.

Policy response

To build and strengthen capacity for health services delivery to address harmful alcohol use and alcohol induced disorders and related conditions.

Policy strategies

The government shall;-

a) Build capacity of health and other social services systems to deliver prevention, treatment and care for alcohol-use and alcohol induced disorders and co-morbid conditions, including support and treatment for affected families and support for mutual help or self-help activities and programs.

b) Support initiatives for screening and brief interventions for hazardous and harmful drinking at primary health care and other settings; such initiatives shall include early identification and management of harmful drinking among pregnant women and women of child-bearing age.

c) Improve capacity for prevention of, identification of and intervention for mothers with harmful use of alcohol.

d) Develop and effectively coordinate integrated and/or linked prevention, treatment and care strategies and services for alcohol use disorders and co-morbid conditions, including drug-use disorders, depression, suicides, HIV/AIDS, TB and Sexual, Gender Based Violence.

e) Ensure universal access to health through enhancing availability, accessibility and affordability of treatment services to all people in need of services.

f) Ensure availability of pharmacotherapy treatment, psychosocial services and other specialized services for alcohol dependence at specialist alcohol treatment services.

PRIORITY AREA 3: COMMUNITY ACTION

Policy Issue:

The community has the capacity to control and regulate alcohol through community decisions and bylaws. Communities shall be supported and empowered by governments and other stakeholders to use their local knowledge and expertise in adopting effective approaches to prevent and reduce the harmful use of alcohol by changing collective rather than individual behavior while being sensitive to cultural norms, beliefs and value systems.

Policy response:

Strengthen communities to take collective action in the control of alcohol use.

Policy strategies:

The government shall;-

a) Support and facilitate local governments and Civil Society Organizations and other stakeholders to identify and implement evidence based interventions at community levels to address alcohol related harm.

b) Support the development of structures for community policing against harmful use of alcohol.

c) Strengthen the capacity of the local governments and municipal councils to coordinate and promote policies to reduce harmful use of alcohol.

d) Mobilize communities to prevent the selling of alcohol to, and consumption of alcohol by, underage drinkers, and to develop and support alcohol free environments, especially for youth and other at risk groups.

e) Empower the community to support affected individuals and their families to access care.

f) Develop and support community programmes and policies for sub populations at particular risk such as young people, unemployed persons and indigenous populations from production and distribution of illicit or informal alcoholic beverages such as sporting events and town festivals.

g) Mobilize cultural and religious leaders to participate in alcohol abuse prevention and mitigation programs.

PRIORITY AREA 4: DRINK-DRIVING POLICY AND COUNTER MEASURES.

Policy issue:

Driving under the influence of alcohol seriously affects a person's judgment, coordination and other motor functions. Alcohol-impaired driving is a significant public health problem that affects both the drinker and in many cases innocent parties. There are strong evidence based interventions for reducing drink-driving. In Uganda the number of traffic-related injuries involving intoxicated pedestrians is substantial and should be a high priority for intervention.

Policy response:

To reduce drink-driving and the harm associated with it.

Policy strategy.

The government shall;-

a) Review and enforce an upper limit for blood alcohol concentration, with a reduced limit for professional drivers and young or novice drivers that meets international standards.

b) Promote sobriety check points and random breath-testing on regular basis.

c) Take administrative measures such as suspension of driving licenses for offenders.

d) Issue graduated licensing for novice drivers with zero-tolerance for drink-driving.

e) Ensure mandatory driver-education, counseling and, as appropriate, treatment programs for alcohol use problems.

f) Conduct public awareness and information campaigns in support of the policy and in order to increase the general deterrence effect.

g) Promote carefully planned, high intensity, well-executed mass media campaigns targeted at specific situations, such as holiday seasons, or audiences such as young people.

PRIORITY AREA 5: ALCOHOL AND THE WORKPLACE.

Policy issue:

The work place provides an opportunity for implementing alcohol control policies. It is an affordable and structured

approach for control of harmful use of alcohol. The employer and employee would benefit from work place alcohol control programs because alcohol causes absenteeism and low productivity. In addition , health costs due to related health problems are reduced.

Policy response:

To prevent and reduce the levels of alcohol-related workplace problems, including low productivity, absenteeism and ill health.

Policy Strategy

The government shall;-

a) Investigate the current evidence base to reduce alcohol-related problems at the work place.

b) Provide alcohol-related brief interventions, treatment and rehabilitation support for persons with alcohol use problems.

c) Develop strategies in the workplace to prevent and reduce alcohol-related harm by introducing awareness initiatives and employee assistance programmes.

PRIORITY AREA 6: AVAILABILITY OF ALCOHOL

Policy issue:

Access and availability of alcohol has a direct relationship to its consumption. This suggests an obvious need for regulation of the availability of alcohol.

Policy response:

To regulate the availability of alcohol, so as to reduce the levels of harmful use by the general public

Policy strategies:

The government shall;-

a) Establish and enforce appropriate systems for:

   i. Regulating the hours of retail sales of alcohol.

   ii. Enforcing the ban on the sale of alcohol to and manufacture of alcohol by minors.

   iii. Banning the sale of alcohol to already intoxicated persons and placing a liability on the sellers to ensure the former's safety.

   iv. Regulate consumption of alcohol at public functions and activities.

   v. Banning the sale, supply or offer of alcoholic drinks to authorized officers in uniform.

b) Strengthen the licensing system in order to regulate the production, import, manufacture and sale of alcohol, advertising and promotion.

c) Impose a ban on illicit production, sale and distribution of alcoholic beverages.

d) Provide for Public Health warning on negative effects of alcohol to be affixed on all containers and packages of alcohol as prescribed by the Ministry of Health and at designated places like schools and hospitals.

PRIORITY AREA 7: MARKETING OF ALCOHOLIC BEVERAGES

Policy issue:

The alcohol industry has a well-resourced marketing program to convince young people to start taking alcohol and users to take more alcohol. Prohibition or restriction of marketing of alcoholic beverages can be highly effective in preventing young people from taking alcohol. Prevention strategies need to use methods similar to those used for marketing such as social media.

It is important that national social marketing campaigns that aim to prevent alcohol-related harms are planned in conjunction with other information initiatives, especially peer education and school-based education programmes that engage parents as well as children and adolescents (minors).

Policy response

Reduce the impact of marketing of alcoholic beverages particularly to children and adolescents (minors)

Policy strategy

The government shall;-

(a) Set up regulatory framework with a legislative basis for alcohol marketing through.

   i. Regulating the content and volume of marketing.

   ii. Regulating direct or indirect marketing in the media.

   iii. Regulating sponsorship activities that promote alcoholic beverages.

iv. Restricting promotions in connection with activities targeting young people.

v. Restricting new forms of alcohol marketing techniques such as social media.

(b) Develop independent statutory bodies of effective systems of surveillance of marketing of alcohol products.

(c) Set up effective administrative and legislative deterrence systems for infringements on marketing restrictions.

(d) Banning any form of advertising that is false, misleading or deceptive or that is likely to create an erroneous impression about the characteristics, health or social effects of an alcoholic drink.

(e) Ban the sale of alcohol in sachets and small packages setting lowest volume to be not less than 250 mls (for spirits), 750 mls for wines and 330 mls for beers.

(f) Ban the involvement of persons below 21 years in manufacture, distribution and sale and any processes related to promotion of alcohol.

(g) Prescribe guidelines for packaging alcohol to include the following information on all containers of alcohol

i. A statement as to the constituents of the alcoholic drink.

ii. A health warning.

PRIORITY AREA 8: TAXATION POLICIES.

Policy statement:

Consumers, including heavy drinkers and young people, are sensitive to changes in the price of alcoholic drinks. Pricing policies can be used to reduce underage drinking, to halt progression towards drinking large volumes of alcohol and/ or episodes of heavy drinking, and to influence consumers' preferences.

Increasing the price of alcoholic beverages is one of the most effective interventions to reduce harmful use of alcohol. A key factor for the success of price-related policies in reducing harmful use of alcohol is an effective and efficient taxation system and a price policy matched by adequate tax collection and enforcement.

Policy response:

To establish, set and regulate price and taxation policies for alcoholic beverages in order to reduce harmful use of alcohol.

Policy strategy:

The government shall;-

a) Maintain a system of excise domestic taxation on alcoholic beverages accompanied by an effective enforcement system which will take into account, as appropriate, the alcoholic content of the beverage.

b) Regularly review taxes in relation to the level of inflation and income to ensure that alcohol is not cheaper than other beverages.

c) Ban the use of direct and indirect price promotions, discount sales, sales below cost and flat rates for unlimited drinking or other types of volume sales.

d) Provide price incentives for healthy non-alcoholic beverages and make them cheaper.

e) Stop subsidies and other incentives to economic operators in the area of alcohol.

PRIORITY AREA 9: REDUCING THE NEGATIVE CONSEQUENCES OF DRINKING AND ALCOHOL INTOXICATION

Policy Issue:

Drinking to intoxication is a major cause of short term alcohol-related illness, injury and associated social problems. Excessive single occasion drinking produces significant and wide-reaching impacts on the health, safety and wellbeing of individuals and communities. Intoxication produces substantial direct and indirect costs, many associated with the increased likelihood of risky behaviors, such as unsafe sex, drink driving and intoxication-related offences such as domestic violence. Preventing intoxication will significantly reduce the harm from alcohol misuse and abuse.

Current evidence and good practices favor the use of interventions that prevent the negative consequences of drinking and alcohol intoxication.

Policy Response

To reduce the incidences of intoxication in drinking environments and ensure proper management of those that get intoxicated

Policy strategies

The government shall;-

a) Regulate the drinking context to minimize violence and disruptive behavior including serving alcohol in plastic containers or shelter proof glass and management of alcohol related issues at large scale public events.

b) Enact laws to prohibit serving alcohol to the point of intoxication and put legal liability for consequence of harm resulting from intoxication to the one who served the alcohol.

c) Develop and disseminate guidelines on responsible serving of alcohol on premises and training staff in relevant sectors on prevention, identifying and managing intoxication.

d) Set limits to regulate alcoholic content in the different alcoholic beverages.

e) Put in place guidelines to care for severely intoxicated people to avoid worsening of the condition.

f) Ensure that all alcoholic beverage packages have consumer information about the product and are labeled with warnings by Ministry of Health to indicate the harm related to alcohol in languages to be prescribed by law.

g) Impose penalties for persons found drunk and incapable or drunk and disorderly in a public place.

PRIORIY AREA 10: REDUCING PUBLIC HEALTH IMPACT OF ILLICIT AND INFORMALLY PRODUCED ALCOHOL

Policy Issue

Production and consumption of illicit or informally produced alcohol has additional negative health consequences due to higher ethanol content and potential contamination with toxic substances such as methanol. It may also hamper government's ability to tax and control produced alcohol. Actions to reduce these negative effects should be taken in accordance to the prevalence of illicit and informally produced alcohol consumption and the associated harm.

Good market knowledge and insight into the composition and production of informal or illicit alcohol coupled with the appropriate legislative framework and active enforcement are also important. These interventions should complement, but not replace other interventions to reduce harmful use of alcohol.

Production and sale of informal alcohol is ingrained in many cultures and is informally controlled. Thus control measures could be different for illicit and informally produced alcohol and should be combined with awareness raising and community mobilization. Efforts to stimulate alternative sources of income are also important to minimize production of informal alcohol.

Policy response

To establish, strengthen and enforce mechanisms to control production and sale of illicit and informal alcohol.

Policy strategies:

The government shall;-

a) Establish good quality control with regard to production and distribution of alcoholic beverages.

b) Regulate sale of informally produced alcohol and bring it into the taxation system.

c) Establish an efficient control and enforcement system, including taxation stamps.

d) Develop and strengthen tracking and tracing systems for illicit alcohol.

e) Ensure necessary cooperation and exchange of relevant information on combating illicit alcohol among authorities at all levels.

f) Issue relevant public warnings about contaminants and other health threats from informal and illicit alcohol.

g) Promote safe alternative livelihoods for people involved in production of illicit and informal alcohol.

PRIORITY AREA 11: PROTECTION OF MINORS FROM EFFECTS OF ALCOHOL

Policy Issue

Consumption of alcohol by minors exposes them to severe social, economic and health consequences. Prevention of alcohol use by minors will ensure reduction of harmful use not only among minors but also in adult life.

Policy Response

To establish effective measures to prohibit sale of alcohol to and by minors

Policy strategies

The government shall;-

a) Require all sellers of alcohol to put up clear and prominent signs at points of sale about prohibition of sale to minors and place liability for the act on the seller.

b) Ban the sale of alcohol in a form or any manner by which it is directly accessible e.g. shelves of shops.

c) Ban manufacture and sale of alcohol containing sweets, snacks and other sweetened drinks and foods to minors.

d) Ban sale of alcohol using vending machines to minimize access by minors.

e) Ban distribution of free alcohol to the public especially minors.

PRIORITY AREA 12: MONITORING, SURVEILLANCE AND RESEARCH

Policy Issue

Responding to alcohol concerns requires ongoing development of the evidence base to inform policy and practice. It is necessary to conduct a comprehensive review of evidence on alcohol consumption and alcohol-related harm and strategies. Government currently lacks a central point for documentation and collection of data to inform stakeholders.

Lack of up to date and appropriate alcohol related research inhibits the development of effective responses.

Inconsistent or inadequate data inhibits the development of effective responses. There is need to scale-up alcohol related research and data collection.

Policy Response

Initiate and implement a comprehensive range of research to develop an understanding of the role of alcohol in our society, and of the extent of alcohol-related harm:

The government shall conduct research to;-

a) Obtain up-to-date data on drinking patterns and trends.

b) Collect specific data for use in targeted interventions.

c) Develop a national framework and tools for the collection, analysis and dissemination of alcohol-related offence information and best practice response procedures in collaboration with law enforcement agencies.

d) Collect, analyze and disseminate data by health facilities and emergency departments in relation to alcohol-related cases.

e) Collect and disseminate information on personal, family, social and economic harm associated with harmful use of alcohol.

f) Audit services for those with alcohol-related problems on a regular basis.

g) Integrate instruction on the addictive nature and health consequences of alcohol into education syllabuses.

6.0 IMPLEMENTATION FRAMEWORK

6.1 Institutional Arrangements

The success of the National Alcohol Policy shall depend on the partnerships forged between all key stakeholders, in particular:

a) Law enforcement
b) Legislators
c) Criminal justice
d) Liquor licensing authorities
e) Health providers
f) Welfare and other social services
g) Parents' groups
h) Educators
i) Road traffic authorities
j) Local authorities
k) Religious and traditional leaders
l) Employers and workers representatives
m) Civil Society
n) Academia (Researchers)

6.2 Implementation and capacity building

Capacity building is critical to the success of the National Alcohol Policy.

Government shall establish mechanisms for;-

a) Disseminating, communicating and promoting the National Policy to key stakeholders.

b) Building partnerships including partnerships between government, civil society organizations and communities. Government shall also develop regulations that limit interaction between the Alcohol industry and; policy makers and implementers to minimize conflict of interest.

c) Participation of media, research institutions, NGOs, CSO, individuals and other organizations in implementing this policy.

The following sectors shall take key responsibility for implementation of the policy;

1. Ministry responsible for Health
2. Ministry responsible for Trade and industry
3. Ministry responsible for Tourism
4. Ministry responsible for Internal affairs
5. Ministry responsible for Justice
6. Ministry responsible for Agriculture
7. Ministry responsible for Education
8. Ministry responsible for Finance
9. Ministry of Gender Labour and Social Development
10. Uganda National Bureau of Standards
11. Uganda Revenue Authority
12. Ministry of Local Government

Sector	Key responsibilities
Ministry responsible for Health	• Ensure that health services respond to those affected. • Provide education, communication, training and public awareness about the dangers of alcohol use. • Conduct surveillance, monitoring and evaluation as well as research on alcohol use. • Reduce public health impact of illicit and informally produced alcohol. • Coordinate alcohol control strategies with those who work in other relevant sectors, including cooperation between different levels of governments, and with other relevant health-sector agencies. • Develop clinical guidelines for interventions against harmful use of alcohol. • Mobilize and allocate resources for alcohol control.

Sector	Key responsibilities
Ministry responsible for Trade and industry	• Regulate marketing of alcoholic beverages. • Restrict price and taxation on alcoholic beverages. • Restrict marketing of alcoholic beverages. • Strengthen the licensing systems for alcoholic beverages.
Ministry responsible for Tourism Wild life and Antiquities	• Disseminate information on alcohol in the country to all tourists
Ministry responsible for Internal affairs	• Disseminate laws on alcohol control. • Promote drunk driving policy counter measures.
Ministry responsible for Justice	• Sensitize public on alcohol control policy/law. • Ensure effective and efficient disposal of alcohol related cases.
Ministry responsible for Justice	• Integrate information on harmful alcohol use in school curricula at all levels. • Supervise school environment to prevent harmful alcohol use. • Integrate child offenders back into school.

Sector	Key responsibilities
Ministry responsible for Education	• Integrate information on harmful alcohol use in school curricula at all levels. • Supervise school environment to prevent harmful alcohol use. • Integrate child offenders back into school.
Ministry responsible for Finance	• Restrict prices and taxation on alcoholic beverages
Ministry of Gender Labour and Social Development	• Sensitize communities on alcohol control policy. • Co-ordinate programs for rehabilitation. • Develop community programs to prevent harmful use of alcohol. • Empower communities to take action.
Uganda National Bureau of Standards	• Ensure that quality and standards of liquor stipulated in the alcohol control policy are upheld. • Disseminate information on trends of substandard liquor.
Cabinet	• Establish budget lines to meet the capital and recurrent expenditures regarding the overall implementation of alcohol policies.

Sector	Key responsibilities
Police	• Educate police officers and other enforcement agencies on alcohol control policy. • Enforce laws on alcohol control. • Collect, analyze and disseminate information on trends of alcohol related offences. • International collaboration to manage cross border alcohol control.
Local Authorities	• Identify and register harmful alcohol use incidents with local councils. • Mobilize communities to prevent sale of alcohol to minors.

6.3 National Action Plans

Government shall develop national alcohol action plans, supported by appropriate budgets. These national action plans shall form part of the annual work plan for the relevant Government Departments and Agencies.

6.4 Legal Framework

The government shall;-

1. Review national health and enforcement policies to ensure that this National Alcohol Control Policy is compatible. The legal framework for the implementation of this Policy shall be developed by government

through review of laws on alcohol and development of regulations.

2. Make Special efforts to mainstream activities of the informal sector for purposes of improving their practices for economic gain and for appropriate regulation while minimizing harmful alcohol sale.

3. Establish a National Alcohol Control Committee (UNACC) to oversee all aspects of the implementation of the policy and the relevant legislation with its secretariat at the Ministry of Health.

The UNACC shall;-

a) Keep statistics on the level of alcoholic drinks consumed and related deaths and carry out research, documentation and dissemination of all relevant information on alcoholic drinks.

b) Promote national treatment and rehabilitation programs.

c) Advise the Minister on the Policies to be adopted with regard to the production, manufacture, sale and consumption of alcoholic drinks and other matters and function as may from time to time be assigned by the Minister.

d) Report to the office of the Prime Minister of Uganda/ President's office, and shall publish an annual report on progress. It shall draw its membership from government officials, representatives of the academic and public health community, representatives of the non-government organizations and civil society.

4. Monitor and support the annual work plans for the relevant government departments.

6.5 Resource mobilization

The government shall finance the capital and recurrent expenditures of the UNACC regarding the overall implementation of alcohol control policies, strategies and plans through:

(a) Inclusion in the medium term expenditure framework in national and local authorities' budgets.

(b) Money obtained from donations and well wishers.

6.6 Monitoring and 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.

Government shall establish a monitoring and Evaluation framework for all sectors and agencies involved in Alcohol Control.

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