



**REPUBLIC OF BOTSWANA**

**NATIONAL ALCOHOL POLICY  
FOR BOTSWANA**

**MINISTRY OF TRADE AND INDUSTRY**

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**GABORONE, BOTSWANA**

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## **Preface**

There is evidence of ill health and other social ills resulting from the abuse of alcohol. This has caused great concern to the Government of Botswana. As a result, the government, in partnership with stakeholders together with development partners developed this policy. The policy was developed through a consultative and participatory process.

Botswana, like so many other countries both within Africa and elsewhere, is going through a period of rapid changes. Traditional cultures are increasingly under pressure and the access to alternative communications and information regarding latest trends in consumer goods particularly amongst young people is having an impact on long standing values within and across communities.

In Botswana authorities, policy makers and the public at large have expressed concerns regarding the increasing number of alcohol-related accidents on the roads, alcohol associated crimes in the communities, binge drinking and intoxication among young people, as well as family conflicts, violence, and low productivity at work.

Government has a duty and responsibility to ensure that the nation is well protected from all forms of harm and enhance its ability to embrace the changing global environment.

In response to this situation, several interventions have been initiated to redress harmful effects of alcohol use, such as the introduction of an alcohol tax levy and controls on retail sales outlets. Despite these important steps, there is a need for a thorough review of alcohol control instruments such as the Liquor Act, to fill important gaps in prevention and treatment, to strengthen existing policies, and to provide better coordination among policies spanning a number of Government sectors/ministries in order to maximize the effectiveness of a national alcohol policy.

This policy addresses issues of production, retailing, distribution, marketing and consumption of alcohol. It also proposes a multi-

sectoral, multi-pronged approach to dealing with especially the harmful and negative impact of alcohol. It has been developed to offer a suitable framework within which Government of Botswana and key stakeholders can develop plans which provide the needs of all the people of Botswana. The policy will be supported by a comprehensive strategic plan that will help guide and coordinate the various efforts in this regard.

This alcohol policy is based on a thorough review of the existing situation in Botswana, and takes into account recent advances in evidence-based alcohol policies as recommended by the World Health Organization, international development agencies, non-governmental organizations, and the public health community.

On behalf of the Government of Botswana, I want to believe that the enthusiasm and partnership exhibited during the development of this policy will continue into the implementation stage.

**Dorcas Makgato-Malesu**  
**Minister of Trade and Industry**

## **Abbreviations**

AIDS	Acquired Immune Deficiency Syndrome
BAC	Blood Alcohol Content
BOTUSA	Botswana United States of America
DUI	Driving Under the Influence
DWI	Driving While Intoxicated
GDP	Gross Domestic Product
HIES	Household Income – Expenditure Survey
HIV	Human Immuno-deficiency Virus
HLSP	Health and Life Science Partnership
ICD	International Classification of Diseases
MTI	Ministry of Trade and Industry
NACA	National Aids Coordinating Agency
NAP	National Alcohol Policy
NFTRC	National Food Technology Research Centre
NGO	Non Governmental Organisation
SENDU	Southern African Epidemiological Network on Drug Use
STEPS	WHO tool for the surveillance of risk factors of non-communicable diseases. A sequential assessment using 3 steps.
USD	United States Dollar
WHO	World Health Organization

# **1. Introduction**

## **1.1 Background**

Alcohol has been traditionally brewed and consumed in many societies and acceptance of consumption of alcohol is part of cultural and social practice. It is accepted in many cultures from time immemorial as a social drink mainly because of its mood changing effects and function as a social facilitator. While these effects are cherished by many individuals, unfortunately the negative impact of harmful drinking can be devastating for individuals, families and nation states.

The acute intoxicating effects of alcohol can lead to a wide range of negative consequences including risk taking behaviour (such as unprotected sexual activity), accidents and injuries (especially while driving vehicles or operating machinery), violence, and acute alcohol poisoning. Some of these negative effects of alcohol can lead to over sixty chronic health problems such as disability in the case of injury, neuropsychiatric and other disorders, or infection with the human immunodeficiency virus in the case of unprotected sexual activity, particularly in areas of very high prevalence such as parts of Africa, as already evidenced by numerous studies in both the developed and developing world. Alcohol poisoning depresses nerves that control involuntary actions such as breathing and the gag reflex (which prevents choking). A fatal dose of alcohol will eventually stop these functions. The commonest sign of excessive drinking is vomiting as alcohol is an irritant to the stomach. There is the danger of being choked by vomitus, which could cause death by aspiration in a person who is unconscious. Critical signs of alcohol poisoning include vomiting, confusion, stupor, seizures, slow breathing, irregular breathing hypothermia and stupor.

It begins with a situational analysis of the current state of alcohol consumption, alcohol-related problems and alcohol control policies in Botswana and the region.

A detailed Glossary of Terms is provided at the end to facilitate better and common understanding of the terms used in this Policy.

## **1.2 The Need for Alcohol Policy**

The National Alcohol Policy is required for appropriate regulation and to protect those at risk of harm associated with the abuse of alcohol. It is also predicated on the belief that while acknowledging the issue of choice to drink alcohol it is also necessary to acknowledge the rights of those who wish not to drink as well as reducing harms for all. The policy is also required to address issues of alcohol both at individual and community/societal levels.

At individual level alcohol policies are needed to:

- Safeguard wellbeing and health and offer protection from harm;
- Increase understanding of harms and benefits;
- Discourage negative drinking patterns;
- Improve the ability to make informed decisions;
- Ensure personal choice and freedom without impinging upon the freedoms of others

At societal level, alcohol policies are required to:

- Reduce the burden of harm due to alcohol abuse/misuse;
- Decrease the cost to the society;
- Ensure public safety;
- Create an informed society;
- Facilitate access to treatment and support services for those who are harming themselves or have been harmed by abuse of alcohol by others.
- Change behaviour by discouraging negative drinking patterns;

This national policy is a framework and is designed to provide a comprehensive guide for priority setting, programme development and implementation, inter-sectoral coordination, and evaluation of effectiveness.

## **1.3 Situation analysis**

The situational analysis consists of sections on types of alcohol, per capita consumption estimates, and demographic trends in consumption, socioeconomic considerations, health consequences, and current status of national health responses.

### **1.3.1 Types of alcohol**

Under usual conditions, beverages produced by fermentation have an alcohol concentration between approximately 5% for beer to 12% for wine. In the production of spirits by distillation, alcohol concentration can achieve an average of 40% or more. There are also new alcoholic beverages that combine distilled or fermented alcohol with sweet flavoured liquids (called 'alcopops') or liquids with alcohol and high concentration of caffeine or other stimulants (called "alcoholic energy drinks"). These latter beverages have become popular among young people in many countries.

In the development of this policy on alcoholic beverages, one of the key areas of focus is the illicit and unregulated production and selling of "home brews" and traditional beer as defined in the liquor act. There are also illicit and popular home brews like *Laelammago* and *Khadi* that are usually consumed in 'shebeens' or 'drinking spots'.

### **1.3.2 Total Alcohol Consumption**

According to the WHO global burden of disease study in 2002, the Sub-Saharan region of Africa (Afro Region E, which includes Botswana), was rated as having the 7th highest consumption of all 14 WHO regions with an estimated 7.1 litres of absolute alcohol consumed per adult per year. When taking into account the percentage of abstainers, the total amount of pure alcohol consumed per adult drinker was 16.6 litres per drinker, which is among the highest rates in the world.

In 2008, the total estimate of recorded and unrecorded adult per capita consumption (three-year average) for Botswana was



8 litres of pure alcohol per inhabitant, well above the regional average (7 litres). The rate of abstainers among the adult population for Botswana was estimated to be 53.5% (37.0% for males and 63% for females). Percentage of current drinkers in Botswana<sup>1</sup> is about one fifth of the adult population. Of those who consume alcohol, more than half (54%) are 'binge' drinkers (more than 5 drinks in one day).

Several conclusions can be drawn from these statistics. First, whereas Botswana ranks in the intermediate range in terms of total alcohol consumption in Africa, heavy episodic drinking ('binge') is concentrated in a significant proportion of the drinkers. Second, considering the rate of abstention in Botswana, alcohol consumption should not be considered normative but rather the choice of a small but significant minority of the population. Thus preserving or protecting abstention from all alcoholic beverages as a choice should be considered an important policy goal, in addition to moderation among those who choose to drink.

### **1.3.3 Demographic Considerations**

In 2008 the population count was 1,802,959.<sup>2</sup> Of these, 38% constituted young people between the ages of 12- 29 and about 60% is below the age of 30.

Demographic considerations are important because harmful drinking patterns begin in late adolescence and alcohol consumption tends to be concentrated in the young adult population, especially in societies undergoing rapid development like Botswana. Greater numbers of young people are enrolled in school for longer periods than previously, and marriage is occurring later than a generation ago, posing new challenges of pre-marital sex, HIV infection, binge drinking patterns, as well as the use of tobacco and illicit drugs (Blum, 2007).

In 1988, a Youth Survey conducted among the Secondary School Students by Molamu *et al* revealed that 24.3% were taking

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<sup>1</sup> Chronic Disease Risk Factor Surveillance Report 2008

<sup>2</sup> CSO, 2008

alcoholic beverages (mainly beer, wine, *chibuku*, spirits, *bojalwa jwa setswana/mabele* (sorghum beer), *khadi*, and others). Initial exposure to alcoholic beverages started with a ceremony (45%), bottle store (24%) or *shebeen* (11.9%), respectively. About seventy four percent of current drinkers had tried alcohol before the age of 18. According to the study, 71.6% of the sample agreed that alcohol consumption was increasing among them.

Another survey, the Global School-based Student Health Survey 2005 has shown that in Botswana 20.6% of students aged 13-15 years are current drinkers (22.8% boys and 18.7% for girls).

Despite these trends in youth drinking, most of the alcohol consumption in Botswana is concentrated in the adult population. According to the Botswana Stepwise approach to Surveillance (STEPS) on Chronic disease Risk Factor Surveillance (2007), 18.8% of interviewed population ( 25-64 years) were current drinkers (30.3 males and 8.8% for females). Among current drinkers 19.6% drank alcohol on 4 or more occasions in the previous week. Regarding binge drinking, the difference between males and females is small with 54.1% of males and 51.8% of females having respectively more than 5 or 4 drinks in one day in the last week.

From the National Household Sample Survey approximately 57% and 40% of female respondents who were separated or divorced respectively drank alone, compared to 17.5% and 18.1% in male respondents. Usual drinking places were 65.5% at home and 14.9 % in bars .While 38.0% of males and 40.0% of females indicated that they drank once a week, 20.2% and 17.7% of the males and females respectively stated that they drank daily.

In summary, the extent of alcohol consumption by youth is a growing concern, to the extent that early initiation to binge drinking patterns predicts alcohol problems later in life. Other population groups in Botswana that might be considered vulnerable to alcohol-related problems are women of child-bearing age and adult men who consume large amounts of unregulated alcohol.

### 1.3.4 Social and economic aspects of alcohol consumption

Botswana has one of the fastest growing economies in the region with a real GDP per Capita (USD) of US\$ 7820. Like many other countries, Botswana is facing the challenges of keeping pace with the rapid socio-economic developments and technological changes that require a stable human resource base. As reported in several studies, increasing alcohol consumption is likely to follow from economic development and adoption of modern lifestyle changes; but with it alcohol-related problems are likely to follow. This in turn is likely to limit the amount of economic growth and increase the demand for costly health and social services necessary to deal with alcohol-related problems.

The Government of Botswana realizes its resource potential and is in the process of reviewing the socio-economic factors that are affecting its population that may be threatening its socio-economic development. From available information that was generated from various studies, there is ample evidence that alcohol abuse is one of the factors that has an impact on socio-economic development. During the National HIV/AIDS assessment for the strategic plan of 2003 – 2009 (NACA, 2002), alcohol was identified as one of six cross cutting themes affecting all sectors of Botswana society. The same document also cited the correlation between alcohol abuse and high risk sexual behaviours including multiple sexual partners, unprotected intercourse, and the exchange of sex for money or drugs. The report also states that for persons infected with HIV, alcohol consumption is further associated with delays in seeking treatment, difficulties with drug compliance, and poor HIV treatment outcomes.

According to a study conducted by Psychologists Botswana (PTY) LTD, alcohol consumption in *shebeens* is associated with a variety of violent behaviours such as rape, murder, theft and fights. Safety of neighbours is also compromised as well as serenity, due to the noise pollution emanating from the *shebeens*. Family members living on a *shebeen* plot witness and

are exposed to other undesirable behaviours such as public indecency and violence.

A study conducted by WHO in 2004 states that a significant proportion of household income was spent on alcoholic beverages rather than on essential needs such as food and clothing. In fact, 20.5% of the urban population income is spent on alcoholic drinks (HIES, 1993/1994)

Absenteeism and conflicts at work often result from alcohol consumption. People under the influence of alcohol are more prone to accidents at work. According to the annual reports of the commissioner of Botswana Police, 1980-1985, alcohol-related injuries, fatalities and motor vehicle accidents increased from 11.4% to 26.8%.

Alcohol consumption at work also impact negatively on productivity as a person under the influence will not be able to perform as effectively as would normally be the case, Absenteeism from work because of alcohol consumption also compromises productivity. This kind of behaviour if not corrected will result in the ultimate loss of revenue of the government in terms of job losses, income maintenance of the unemployed and treatment costs for people with alcohol-related diseases.

In summary, in Botswana there is evidence that alcohol consumption is associated with social and economic consequences, resulting in an increase of expenses within the health and social system thus contributing to loss of productivity and social disruption.

### **1.3.5 Alcohol consumption and health consequences**

The level of alcohol consumption in a population is an important determinant of health and social wellbeing. In any given society, the level of alcohol-related problems tends to rise and fall with the level of consumption. In the African Region and particularly in Botswana alcohol consumption can be characterised by high levels of intake among those who drink,

ready-availability, affordability and popularity of home produced beverages, and high prevalence of alcohol related problems.

A 2006 national "Study on the existence of *Shebeens* in Botswana and alcohol consumption patterns in *Shebeens*" has shown that large quantities of alcohol were being consumed in one occasion (some individuals drink up to 9.3 litres of alcohol per day but on average consumption was 4.2 litres per person per day). From those consuming, 17.1% presented with alcohol dependence symptoms. More than 85% indicated that they drank commercially brewed sorghum beer. Usually the operators of the *shebeens* use their family members to help run the *shebeen*. The study has shown that 54.3% of the operators and 31.3% of *shebeens'* family members drank alcohol.

In the Report of the National Workshop on Alcohol, Other Substance Abuse and HIV/AIDS, 2003, presenters articulated the association between alcohol abuse and HIV/AIDS in Southern Africa. Results of a study on "HIV risk factors among patients with tuberculosis in Botswana", published in 2002, showed that among tuberculosis patients in Botswana, those who used alcohol or whose partners used alcohol before sex were 6.8 times more likely to have HIV infection and that tuberculosis patients who drank alcohol during treatment were 3.8 times more likely to interrupt treatment than those who did not drink alcohol during treatment.

Study findings published in 2005 established the link based on empirical evidence between alcohol abuse and gender-based violence, which render victims vulnerable to HIV/AIDS in Botswana

From the Health Statistics Unit of the Ministry of Health 2004, published in 2007, there was a significant amount of mental ill-health associated with alcohol abuse, including alcohol psychosis and alcohol dependence syndrome that were reported in psychiatric units, in both out-patients and in-patients.

According to the 2003 SENDU report, alcohol remains the most common primary substance of abuse reported by patients seen

at the four psychiatric centres with homebrews being the most common type of alcohol abused.

These findings indicate that in Botswana alcohol abuse and dependence place a significant burden on the health care system and account for a significant proportion of premature mortality especially from unintentional and intentional injuries.

### **1.3.6 Political and legislative measures**

The Government of Botswana is greatly concerned about alcohol-related problems and their impact on public health and economic development. The government introduced the following measures:

- Amendment of Road Traffic Act by applying stiffer penalties on road traffic offenders especially alcohol related offences.
- Introduction of 30 % Levy on alcoholic beverages
- Introduction of Liquor Act and related Regulations, which include stringent licensing: introduction of shorter operating hours; 500 metre distance from schools, churches, highway and major roads for liquor operations and introduction of stiffer penalties to transgressors. (Liquor Regulations 2008, Statutory Instrument No, 26 of 2008)
- Introduction of education campaigns e.g., sobriety campaigns by Botswana Police, recruitment of campaign manager who will coordinate public education efforts on the ill effects of alcohol and other interventions.

These measures, combined with other alcohol control measures recommended by the National Strategic Framework for Combating Alcohol Abuse, constitute an important foundation for a more effective policy response to alcohol-related problems. The major challenge is ensuring that alcohol policies become part of a larger public health agenda for the nation. Another challenge is ensuring that the country can raise enough money to support the implementation of a strategic plan, including the establishment of new prevention and treatment services, plus a way to coordinate, monitor and evaluate the national policy framework.

### **1.3.7 Specialised treatment and early intervention services**

Government is the chief provider of health services in the country with mines and churches contributing significantly. There is also a growing private sector which contributes mainly through health insurance (medical aid schemes) and workplace wellness programs. Individuals with alcohol induced psychiatric conditions and alcohol problems are treated mainly in mental health services both institutional and community based.

Health services are arranged in vertical hierarchy of increasing sophistication and coverage from health post through clinics, primary hospitals district hospitals up to national referral hospitals.

There are few specialised services for alcohol-related problems in the country. There is currently (2010) only one psychiatric hospital (with minimal detoxification facilities) where severe alcohol dependence can be treated and five psychiatric units in general hospital with inpatient beds. There are approximately five psychiatrists with little specialisation in alcoholism treatment and no specialised rehabilitation centres. Because of the stigma associated with mental health services, people with alcohol dependence may be reluctant to approach mental health services. There is a general lack of capacity to assess and deal with alcohol problems in primary health care and emergency settings, where many people with alcohol-related problems are likely to be seen for alcohol-related conditions (such as injuries, depression, hypertension) that are secondary to their heavy drinking. There is an absence of outpatient counselling that can be delivered in non stigmatising settings.

Botswana has an inadequate supply of health professionals in relation to demand and those with requisite skills are not equitably distributed across the country. This combined with the general lack of specialised services signals the need for professional training, and the establishment of a network of treatment programs that can coordinate a nation-wide treatment response.

### **1.3.8 The Alcohol beverage industry**

Alcohol beverage industry is one of the major contributors to the economy of Botswana through revenues and employment. The marketing techniques used by the alcohol beverage industry are many fold. In addition to sponsoring cultural and social events, and sports, they also use other innovative marketing techniques. However, the above stated contributions may be outweighed by the social and health impact due to alcohol abuse.

There is a large unregulated informal market of traditional beer and other alcoholic produce. Some are commercially produced while others are home-made. These alcoholic drinks are sold through *Shebeens*/drinking spots and these establishments also sell a variety of illicit and untested alcoholic beverages. They also buy and sell commercially produced and licensed alcoholic beverages and provide a conduit for consumers when regulated premises shut down.

## **2 Goal and Overall Objective**

### **2.1 Goal**

The goal is to have a healthy and productive nation with reduced morbidity, mortality and negative socio-economic consequences from harmful use of alcohol.

### **2.2 Overall Objective**

The overall objective of the policy is to provide an institutional framework for a multi-sectoral implementation of strategies at national, district, local and community levels

## **3 Guiding principles**

The following **guiding principles** will guide the implementation of the policy:

- **Protection of vulnerable populations such as youth and women** – guidance provided under the alcohol policy is



based on the fundamental principle that it is up to the Government to provide protection to its citizens from alcohol-related harm, particularly harm to women and youth who are more vulnerable to developing alcohol related conditions.

- **Freedom to choose** –While there is choice to drink or not to drink alcohol, the freedom should not impinge on the health, safety and security of anyone.
- **Community participation** – Communities are essential partners for the implementation of the policy. Their involvement is crucial to ownership and effectiveness of programs aimed at reducing harmful effects of alcohol.
- **Inter-sectoral approach** – multi-sectoral coordination is essential for harnessing comparative advantages and strengths towards the common goal of reducing alcohol related harm to society.
- **Long term commitment** – Lasting political and societal commitment is required to ensure a change in social norms and values.
- **Evidence-base** approach – To ensure that effective and efficient strategies are used to address alcohol abuse; one important policy principle is the emphasis on evidence-based approaches. All interventions and programmes will be based on evidence locally and internationally sourced.
- **Individual Responsibility**: It recognises the freedom of choice but also requires that individuals should bear responsibility for their actions. Responsibility to reduce alcohol-related problems rests with all living in Botswana.

#### **4 Main priorities and areas for action (Policy Thrusts)**

In pursuing the goal and based on the guiding principles, the following main areas of action, objectives and measures are identified. Jointly they constitute a means to increase the impact of the national alcohol policy.

##### **4.1 Intersectoral collaboration**

A well-coordinated and sustained effort is required to impact on the modifiable determinants like price, outlet locations, service

practices, law enforcement, opening hours, promotions, minimum age, and social norms and values which need to be targeted for the implementation of the Alcohol Policy by various stakeholders.

**Objective:**

To improve coordination of interventions of all stakeholders

**Policy Statements**

- a) The Government shall strengthen the Inter-Sectoral Committee by formalising its terms of reference, which will ensure strategic guidance, coordination and supervision of the national policy. This will be chaired by Ministry of Health and include key stakeholders.
  
- b) The Inter-Sectoral Committee shall assist government agencies, NGO's, etc. in the implementation, monitoring and evaluation of the National Alcohol Policy.
  
- c) The Inter-Sectoral Committee shall provide support to governmental bodies and other stakeholders at national and sub-national levels, to give high priority to the prevention of harmful use of alcohol, with an increased investment in the implementation of policies known to be effective.
  
- d) The Inter-Sectoral Committee shall clarify the roles and responsibilities of different stakeholders not delineated here in the policy.

**4.2 Increasing community action and support**

The recognition of alcohol-related harm and active participation of the community through public education will contribute to the success of adopted policy measures.

## **Objective:**

To enhance active participation of the community in enforcement of regulations and reduction of alcohol related harm.

## **Policy Statements**

- a) The Ministry of Trade and Industry in collaboration with relevant partners shall support communities to participate in implementing and monitoring nuisance reduction of both home-based and commercial sale and distribution systems through close working relations with the authorised officers.
- b) The Ministry of Health in collaboration with other stakeholders shall develop effective educational materials and campaigns. These will contribute to raise awareness on harmful use of alcohol, alcohol-related consequences (including violence, drink-driving and workplace drinking) and existing legislation, taking into account the need to strengthen public support for effective alcohol policies.
- c) Communities, through 'Neighbourhood Watch Committees' shall support the crime prevention, reduction of illicit alcohol production and selling, as well as social harm reductions.
- d) The Ministry of Defence, Justice, and Security shall sensitise and support communities through formation of crime prevention, neighbourhood watch committees that will promote effective collaboration between the police and community
- e) The Ministry of Local Government shall enforce and monitor implementation of alcohol related legislation through Dikgosi, Bye-Law Enforcement Officers and Environmental Health Officers.

- f) Local political, cultural, youth and religious leadership, civil society and other community formations shall augment efforts of the law enforcement agencies.
- g) Individuals shall be encouraged to take responsibility for their own actions. Those under the influence of alcohol will be liable to prosecution by law for being a public nuisance and disturbing peace and endangering the lives of others if they stray onto roads, make unsuitable utterances and other related offences.

### **4.3 Strengthening public education and awareness**

Availability of appropriate information of the harms will lead to the reduction of alcohol abuse/misuse.

#### **Objective:**

To create awareness about and to reduce the harmful use of alcohol among the general population.

#### **Policy Statements:**

- a) The Ministry of Labour and Home Affairs in collaboration with the Ministry of Health shall provide leadership in the development of initiatives on alcohol at the workplace, aimed at educating, protecting and assisting employees.
- b) The Ministry of Education and Skills Development in collaboration with the Ministry of Health shall develop curricula contents to be integrated in primary and secondary schools on substance abuse in general and on harmful use of alcohol in particular.
- c) The Ministry of Health shall catalyse and coordinate extensive mass campaigns across sectors on the effects of alcohol consumption particularly harmful use (abuse) of alcohol and on skills and on available interventions to reduce or stop harmful use of alcohol.

- d) The Ministry of Youth, Sports and Culture in collaboration with the Botswana National Youth Council shall engage tertiary institutions in developing and implementing innovative alcohol related interventions.
- e) The Alcohol industry shall conduct public awareness as part of Corporate Social Responsibility on drinking related health impacts as well as public safety and amenity.

#### **4.4 Reducing the health impacts of alcohol abuse**

Interventions by the health sector through user-friendly facilities and programmes targeting those who drink to intoxication and those who are long-term heavy drinkers (alcoholics) can reduce the health impacts of alcohol abuse.

##### **Objective:**

To enhance the ability of the health sector to holistically address issues/problems related to alcohol.

##### **Policy Statements:**

- a) The Ministry of Health shall ensure the availability of counselling and brief interventions in relevant health facilities, especially at primary care level, and in other settings such as social welfare, accident and emergency departments, workplaces, and educational institutions.
- b) The Ministry of Health shall ensure that people with alcohol-related problems in need of treatment and rehabilitation have access to non-stigmatised and confidential evidence-based treatments at user-friendly health facilities and community-based services.
- c) The Ministry of Health in collaboration with the Ministry of Education and Skills Development and other relevant stakeholders shall develop curricula for health professionals on issues related to alcohol.

- d) The Ministry of Health shall expand capacity in implementing identification and intervention programmes by educating and training professionals in health care, social service, security forces and criminal justice settings.
- e) The Ministry of Health shall give greater attention to the organisation, integration and delivery of treatment services at the village, district and national levels ensuring availability, equity and rational use of the services.
- f) All actions and means shall be in full compliance with the Laws of Botswana

#### **4.5 Ensuring public safety and amenity**

Enforcement of existing measures such as current Blood Alcohol Concentration (BAC) checks, severity of penalties imposed and on-going awareness campaigns will form the basis for the success of this measure.

##### **Objective:**

To reduce the incidence of drink-driving and ensure road safety for all road users.

##### **Policy Statements:**

- a) The Ministry of Defence, Justice and Security in collaboration with the Ministry of Transport and Communications shall plan and develop drink driving initiatives aimed at educating and protecting road users and preventing and reducing alcohol related road traffic accidents and injuries. The maximum blood alcohol concentration limit as decided by the relevant authorities will be maintained and enforced, using the most effective deterrence techniques such as random breath tests and sobriety checkpoints.
- b) The Ministry of Defence, Justice and Security and the Ministry of Health in association with appropriate

stakeholders shall develop and implement appropriate strategies for reduction of harmful use of alcohol including driving under the influence of alcohol.

#### **4.6 Responsible marketing**

Levels of alcohol consumption, and alcohol-related problems and harm are related to the availability of alcohol. Limits on availability through a licensing and regulatory system that will bring under control illegal production and trading as well as sales restrictions by time and place (restriction on number, types and operating hours of outlets) and a culturally appropriate age limit that is effectively enforced will be prioritised, implemented and closely monitored.

##### **Objective:**

To regulate the availability of alcoholic beverages/liquor including production, selling, promotion, marketing and advertisement in order to reduce alcohol abuse and harm.

##### **Policy Statements:**

- a) The Ministry of Trade and Industry and other relevant ministries and departments shall review existing legislation and regulations to ensure that they work in synergy with the alcohol policy, including the revision of licensing regulations on production and retailing/selling and to the extent possible importation. The exercise of this responsibility should be with meaningful consultation with appropriate stakeholders.
- b) The Ministry of Trade and Industry in collaboration with the Ministry of Local Government shall periodically review penalties relating to the production and selling of alcohol particularly to minors and impose appropriate sanctions, such as license suspensions, withdrawals and fines.
- c) The Ministry of Trade and Industry in collaboration with the Ministry of Justice, Defence and Security (Police) and

with the District Councils (Bye-law enforcement) shall improve compliance through strict enforcement of legislation and other control or regulatory instruments.

- d) The Ministry of Trade and Industry and District Councils shall introduce licensing and regulation processes regulating all forms of public nuisance associated with retailing and consumption of alcohol.
- e) The Ministry of Health with the support of capable independent institutions such as the National Food Technology Research Centre (NFTRC) shall test all alcoholic beverages, including home brews to determine their alcohol content which will be required by law to be put in labels on such vessel as may be in use.
- f) The Ministry of Trade and Industry together with relevant stakeholders shall develop a code of conduct to regulate marketing, selling and promotions. Avoiding advertising and marketing: (a) targeting those below the legal age of drinking; (b) depicting irresponsible drinking; (c) encouraging choice with higher alcohol content; (d) depicting pregnant women; (e) suggesting enhanced performance (sexual/social); and (f) claiming curative qualities or suggesting consumption for health reasons.
- g) The Government shall ensure that all commercial communication contains responsible messages.
- h) The Ministry of Trade and Industry in collaboration with Ministry of Finance and Development Planning shall continue to apply taxation on alcohol products.
- i) The Government shall, from time to time, review levy on alcoholic beverages and use some of these funds for programmes related to alcohol abuse. A Levy Implementation Committee chaired by the Ministry of Health will be responsible for allocation of resources.



## **4.7 Addressing illegally and informally produced alcohol**

Illegal and informal production and distribution are an important aspect of alcohol supply that needs to be brought under effective Government control. There is also need to address support mechanisms for alternative means to generate income in markets with substantial home production.

### **Objective:**

To reduce and ultimately stop the production and selling of illegally and informally produced alcohol.

### **Policy Statements:**

- a) The Inter-Sectoral committee, through the Ministry of Trade and Industry and in collaboration with the Ministry of Defence, Justice and Security (Police) and with the District Councils (Bye-law enforcement) shall work towards the control of all forms of illicit trade in alcoholic products and illicit brewing, and will take legislative and administrative measures to ensure that all unit packages of alcoholic products and any packaging are marked to assist identification of the origin and alcohol content of the products.
- b) The Ministry of Trade and Industry in collaboration with the Ministry of Labour and Home Affairs and Ministry of Local Government shall develop measures that will contribute to provide alternative sources of income to those engaged in illicit production and sales.

## **4.8 Research, networking and exchange of information**

Responding to alcohol problems requires the use of existing evidenced-based approaches and ongoing development of evidence that will inform the policy and strategic plan at national, regional and global levels.

**Objective:**

To continuously provide evidence to inform policy development and implementation of programmes

**Policy Statements:**

- a) The Ministry of Health in collaboration with relevant partners and training institutions such as universities and research bodies shall engage in policy research in order to evaluate the effectiveness of the alcohol policy and strategic plan and to close the knowledge gap.
- b) The Ministry of Health and Ministry of Trade and Industry in collaboration with relevant partners shall contribute to maximising and reinforcing the impact of the national policy through networking and international collaboration.
- c) The Ministry of Health shall lead research and ensure regular monitoring of alcohol consumption, health and socio-economic related problems and improve data collection in coordination with regional and global surveillance systems on alcohol and health already in place.
- d) The Ministry of Trade and Industry in collaboration with relevant partners shall develop a comprehensive study of alcohol production and distribution within the informal sector.

## Glossary of terms

**Alcohol** (WHO): Alcohols are a large group of organic compounds " derived from hydrocarbons and containing one or more hydroxyl (-OH) groups. Ethanol (C<sub>2</sub>H<sub>5</sub>OH, ethyl alcohol) is one of this class of compounds, and is the main psychoactive ingredient in alcoholic beverages. Alcohol is also used to refer to alcoholic beverages. Ethanol results from the fermentation of sugar by yeast. Under usual conditions, beverages produced by fermentation have an alcohol concentration of no more than 14%. In the production of spirits by distillation, ethanol is boiled out of the fermented mixture and re-collected as an almost pure condensate. Apart from its use for human consumption, ethanol is used as a fuel, as a solvent, and in chemical manufacturing.

**Alcohol policy:** Alcohol policy refers to the set of measures in a jurisdiction or society aimed at minimizing the health and social harms from alcohol consumption.

**Alcoholic beverage:** is defined as any liquid intended for drinking that contains minimum ethanol content as determined by the Government of Botswana and also referred to as liquor in the Liquor Act 2003 (ACT NO. 9 of 2004).

**Alcohol dependence:** Is a category in the ICD-10 classification of mental and behavioural disorders, defined as a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value. A central characteristic is the desire to drink alcohol.

**Alcohol-related harm and problems related to alcohol consumption:** Can be used as equivalent terms, referring to the wide variety of health and social problems, to the drinker and to others, at individual and at collective levels, in which alcohol plays a causal role.

**Brief intervention** (WHO): A treatment strategy in which structured therapy of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of a psychoactive substance or (less commonly) to deal with other life

issues. It is designed in particular for general practitioners and other primary health care workers.

**Drink-driving** (WHO): The generally favoured term for the criminal action of driving a vehicle with a blood alcohol level over a specified limit. The legislation that criminalizes this action is called a "per se" law; reflecting the supplementation of older legislation by per se laws, the term "drinking-driving" includes, but is not limited to, drunk driving, driving under the influence (DUI), and driving while intoxicated (DWI).

**Episodic heavy drinking or binge drinking:** Refers to a drinking occasion that includes consumption of at least 60g of alcohol although other definitions (such as 5 or more 'standard drinks') can also be used. In common terms this is frequently called 'binge drinking'.

**Harmful use of alcohol:** A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences. This is a category in the ICD-10 classification of mental and behavioural disorders, which refers to a condition in which physical or psychological harm has occurred to the individual as a result of his or her drinking. "

**Hazardous alcohol consumption:** Can be defined as a level of consumption or pattern of drinking that is likely to result in harm should the present drinking habits persist.

**Heavy alcohol consumption:** Defined as a pattern of drinking that exceeds a specified daily amount (e.g. three drinks a day) or quantity per occasion (e.g. five drinks on an occasion, at least once a week) and is considered high-risk drinking.

**Low-risk drinking:** For Men is defined as drinking no more than 2 – 3 standard drinks per day with at least two alcohol free days per week.

For Women is defined as drinking no more than 1 – 2 standard drinks per day with at least two alcohol free days per week.

A person should drink less than the suggested above, when: (a) There is a family history of alcoholism; (b) Being on certain medications; (c) Weighting less than other people for gender and height; (d) Not having eaten anything recently.

A person should not drink at all if he/she is: (a) Pregnant; (b) Driving or undertaking other activities that involve risk; (c) Have health problems which may be made worse by alcohol; (d) Taking medicine which directly interacts with alcohol.

**Rehabilitation:** Rehabilitation follows the initial phase of treatment (which may involve detoxification and medical and psychiatric treatment). It encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training, and work experience. There is an expectation of social reintegration into the wider community.

**Standard drink:** A volume of beverage alcohol ( e.g. a glass of wine, a can of beer, or a mixed drink containing distilled spirits) that contains approximately the same amounts (in grams) of ethanol regardless of the type of beverage. In the UK, the term "unit" is employed, where one unit of an alcoholic beverage contains approximately 8-9 grams of ethanol; in North American literature, "a drink" contains about 12 grams of ethanol. In other countries, the amounts of alcohol chosen to approximate a standard drink may be greater or less, depending on local customs and beverage packaging.

***Shebeen* or 'drinking spot':** A home or residence where alcoholic beverages are sold. These are common and very popular in many communities. Shebeens also operate as unlicensed and unregulated retailers of beer, wines, traditional beer and in some cases some hard liquor.