DESK REVIEW OF THE
BOTSWANA NATIONAL ALCOHOL POLICY

FINAL REPORT

SUBMITTED TO MINISTRY OF HEALTH AND WELLNESS BOTSWANA

14 SEPTEMBER 2017

FOREWORD

Harmful use of alcohol has serious public health consequences and is considered one of the main risk factors for public health globally, including in Botswana. Alcohol related death and burden of disease have been on the rise in the last decade in spite of accelerated measures taken globally to reduce them. In Botswana, harmful alcohol consumption has been associated with several non-communicable diseases, high rates of HIV infections, high incidences of gender based violence- especially intimate partner violence- increased road traffic fatalities as well as other severe socio-economic consequences for drinkers, their households and wider communities.

Alcohol has been part of Botswana's history for many years and has been an important component of cultural festivals, weddings and other traditional ceremonies. With changing social organization, values and lifestyles, day-to-day revelries and other pleasure activities have multiplied over the years and so have drinking opportunities, the number of drinkers and the amount of drinking. This has made harmful drinking difficult to control. However, the Government has demonstrated commitment to address problems related to harmful alcohol consumption and has over the last decade put in place a number of legal, policy and programmatic measures to control alcohol related harm. In 2008 the Government introduced a tax levy on all commercially brewed alcohol beverages, followed by a National Alcohol Policy 2010 and other subsequent legal measures. Today, the Alcohol Division in the Ministry of Health and Wellness coordinates a national response to harmful alcohol use under the overall strategic framework of the National Alcohol Policy 2010.

Alcohol abuse is not Botswana's only challenge the country is also grappling with HIV and AIDS, gender based violence and non-communicable diseases, among other challenges. There has been sustained political, social and economic commitment to addressing each of these with the Government taking the lead in a number of ways. Studies have shown that alcohol consumption is closely linked with HIV infections, gender based violence and non-communicable diseases.

The National Alcohol Policy 2010 somewhat addresses some of these linkages but there are gaps in comprehensively dealing with all the problems as a composite. This study is intended to establish critical linkages between the alcohol abuse and HIV/AIDS, GBV and NCDs.

The Government through the Ministry of Health and Wellness is partnering with development partners, the United Nations Development Programme Botswana and the World Health Organization, to complete this desk study which highlights critical synergies in the interventions to address harmful alcohol consumption, HIV/AIDS, non-communicable diseases and gender based violence. The recommendations are expected to help improve the coordination of the interventions to these national problems both at strategic and programmatic levels.

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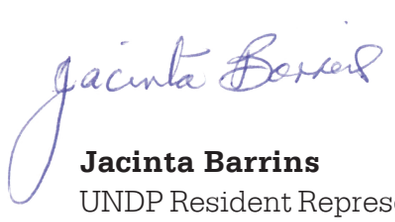

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APC	Alcohol per capita Consumption
AUD	Alcohol Use Disorders
BAIS	Botswana AIDS Impact Survey
CBO	Community Based Organization
GBV	Gender Based Violence
HED	Heavy Episodic Drinking
HIV	Human Immune-deficiency Virus
IPV	Intimate Partner Violence
KSWS	Kagisano Society Women's Shelter
NACA	National AIDS Coordinating Agency
NCD	Non-Communicable Disease
NGO	Non- Governmental Organization
PMTCT	Prevention of Mother to Child Transmission
SADC	Southern Africa Development Community
SDG	Sustainable Development Goals
UN	United Nations
VAW	Violence against Women
WHO	World Health Organization

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1 INTRODUCTION

Botswana is grappling with a growing alcohol problem that is increasingly becoming burdensome to the country's development. Studies have shown that alcohol is widely consumed in Botswana (Weiser et. al., 2006; Obot and Pitso, 2011; Phorano, Nthomang and Ntseane, 2005; Finlay and Jones, 1982; Sinkamba 2015). Both men and women drink to problematic proportions, but generally alcohol use disorders and associated harm affect more males than females (Weiser et. al., 2006; Republic of Botswana, 2007). Globally, harmful use of alcohol poses serious public health consequences and is considered one of the main risk factors for public health (WHO, 2011). It is a key determinant of morbidity and mortality as well as a leading cause of road traffic casualties.

Botswana presents a unique situation characterised by high levels of harmful alcohol use, high HIV prevalence rates, high levels of gender based violence (GBV) as well as emerging problems of non-communicable diseases (NCDs) (WHO, 2014; Republic of Botswana, 2014; Gender Links, 2012). These problems, each with complex age, sex, education and cultural dimensions, have intricate causal relationships that should be highlighted in developing meaningful and functional responses.

In 2010 the Government of Botswana approved a National Alcohol Policy to provide a framework for a coordinated national response to the alcohol problem. Several other measures were subsequently taken to give effect to the policy and to reduce alcohol related harm among the population. Chief among these were the Traditional Beer Regulations of 2011, Road Traffic (Limit of Alcohol) Regulations of 2013, public education campaigns and, more recently, publication of convicted drunk drivers' names in the Government newspaper, the Daily News. The boldest and most controversial measure ever taken to control harmful drinking in Botswana was the Alcohol Levy, introduced in 2008, and later administered under the policy after 2010.

The overall scope, implementation and impact of the National Alcohol Policy has yet to be comprehensively evaluated and the critical linkages between alcohol consumption and HIV/AIDS, GBV and NCDs have not been fully articulated in the policy.

This report presents the outcome of a desk review carried out to highlight the Alcohol Policy gaps in addressing HIV/AIDS, GBV and NCDs and to assess the overall scope, content and application of the policy. The report is structured according to the two phases that the review followed: the desk review and the stakeholder consultations. The recommendations are integrated, however, to present a single, consolidated understanding.

2 GOAL & OBJECTIVES

The aim of this review is to identify policy gaps that need to be addressed to optimize the alcohol response; to mainstream HIV/AIDS, GBV and NCDs into the policy and to align the overall response with the over-arching 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs).

2.1 SPECIFIC OBJECTIVES

- To identify gaps in the National Alcohol Policy in terms of how it addresses HIV, GBV and NCDs.
- To identify evidence based policy options and practical measures that address the harmful use of alcohol in concert with HIV prevention and treatment outcomes and reduction of NCDs and GBV, and attainment of the SDGs.
- To analyse the current institutional framework for the coordination and implementation of the National Alcohol Policy both at local and central government level and recommend appropriate action.
- To recommend HIV, non-communicable diseases and gender based violence issues relevant for revising the current alcohol policy as well as issues related to alcohol marketing and diversion laws and coordination mechanisms
- To propose a feasible time frame for subsequent policy and strategic reviews.

2.2 REVIEW QUESTIONS

The review was guided by the following questions.

- Have strategies adopted by the policy been effective? What are the key achievements to date? What are the main implementation challenges?
- Are there any critical areas that should be part of the alcohol response but are not covered by the policy?
- Are there strong linkages between alcohol use, HIV, GBV and NCDs? If so, does the alcohol policy adequately address HIV, GBV and NCDs; or conversely, do the HIV and AIDS policy and the policy on Gender and Development adequately address harmful alcohol use?
- What policy options can be adopted to strengthen the current alcohol policy to address HIV, GBV and NCDs?
- What areas of the alcohol policy need to be strengthened or adjusted to align it to the SDGs?
- Is the current institutional framework sufficient to coordinate a multi-sectoral response espoused by the policy? What areas need to be strengthened to ensure a coordinated and comprehensive multi-sectoral approach to addressing harmful alcohol use?
- Is the existing legal framework sufficient to deal with emerging challenges such as alcohol marketing?
- Are there policy level, programme level or other recommendations that can be made to enhance the effectiveness of the alcohol response?

PART ONE

3 DESK REVIEW

3.1 METHODOLOGY

The desk review was a qualitative process carried out in two phases. Phase one covered three activities; firstly, a detailed search, synthesis and analysis of international, regional and local literature on alcohol, HIV/AIDS, GBV and NCDs to 1) explore public health and development challenges associated with alcohol use 2) build understanding of the complex interplay between alcohol, HIV/AIDS, GBV and NCDs, and 3) identify challenges and opportunities for the national response against harmful alcohol use. Most of the international and regional literature used was available in reports, journals and other publications online, although text books provided critical theoretical frameworks for analysis of the material. Local content was made available from literature collections of the Alcohol and Substance Abuse Division as well as a few online journal publications.

Secondly, it was an analysis of the national alcohol policy, the national policy on HIV and AIDS, the national policy on gender and development and the response to NCDs to highlight gaps between the alcohol response, the HIV/AIDS response, the response to GBV, the NCDs response and to explore policy options for mainstreaming HIV/AIDS, GBV and NCDs into the national alcohol policy. This second step was analysis-centric, focusing on individual problems and the policy options or technical solutions that have been adopted for each to determine how appropriate, rational and inclusive the solutions are, especially in addressing linkages with other related problems. For example, the approach analysed HIV/AIDS and individual policy options taken to address it to determine whether such options addressed critical linkages with related problems like harmful alcohol consumption.

Thirdly, it was an analysis of policy outcomes to gauge the effectiveness of strategies adopted by the alcohol policy and its strategic plan. The approach was to identify the individual forms of alcohol related harm and assess the strategies adopted in the National Alcohol Policy to address them (policy priority areas) in terms of their appropriateness (placing them in the context of the Global Strategy Against Alcohol Use as a guiding framework and any existing local literature on the alcohol problem); their effectiveness (looking at available evidence of success of the strategies); unintended effects; and feasibility (technical feasibility). This exercise involved analysis of implementation reports from the coordinating division, analysis of previous evaluations of the policy and other related reports. A major limitation was that detailed implementation reports of various strategies were unavailable. Primary quantitative data from health facilities, police and the Alcohol and Substance Abuse Division was also unavailable. Statistics on drink-driving was obtained from a Police report made available through the Alcohol and Substance Abuse Division.

3.2 GLOBAL ALCOHOL CONTEXT

Alcohol consumption and problems associated with it vary extensively across the world, but the burden of disease and death remains significant in most countries. Global statistics show that wealthier countries have the highest alcohol per capita consumption (APC) and the highest prevalence of heavy episodic drinking among drinkers (WHO 2014, 40). However, higher mortality and other harmful effects are by far felt the most among lower income countries, partly due to drinking patterns (harmful patterns) and age structures of their populations (younger populations) (WHO, 2011).

3.2.1 ALCOHOL RELATED MORBIDITY AND MORTALITY

Research has shown that alcohol is a causal factor in 60 types of diseases and injuries and a component cause in 200 others (WHO 2014). Alcohol related morbidity and mortality have been on the rise over the last decade, in spite of multiple measures taken globally to address harmful alcohol consumption. Alcohol-attributable deaths grew by 32% in real terms from 2.5 million people in 2004 (3.8% of global deaths) to 3.3 million people in 2012 (5.9% of global deaths); and the alcohol related global burden of disease grew from 4.5% in 2004 to 5.1% in 2012 (WHO 2011, 5; WHO 2014, 16). Currently, harmful use of alcohol ranks among the top five risk factors for disease, disability and death throughout the world (WHO 2014).

The most common health problems associated with alcohol consumption are neuropsychiatric disorders; other non-communicable diseases such as cardiovascular diseases, liver cirrhosis and various cancers (WHO 2010); and infectious diseases such as tuberculosis and HIV/ AIDS (Lönnroth et al., 2008. Quoted in WHO 2014). Alcohol is also linked to a number of detrimental socio-economic consequences including violence, child neglect and abuse, absenteeism in the workplace, economic hardships and increased road traffic casualties and fatalities (WHO 2014).

3.2.2 HEALTH AND OTHER BENEFITS OF ALCOHOL

There is growing literature showing that not all forms of alcohol consumption have negative health effects and/or leads to abhorrent social-economic consequences. Some researchers have shown that some form of moderate drinking during meals may protect healthy adults from developing coronary heart disease (NIAA, 2015). Additionally, in many countries, the alcohol industry is an important source of employment and generates substantial tax revenue for government. However, alcohol is mostly consumed in quantities and patterns that are detrimental to people's health. All factors considered, the overall net effect of alcohol consumption is negative to society when its economic and health gains are weighed against the public health burden and other opportunity costs (Naik & Lal 2003).

3.3 ALCOHOL CONSUMPTION IN BOTSWANA

3.3.1 VOLUME OF CONSUMPTION

Studies have shown that for most of the diseases and injuries which have alcohol as a component cause, there is a dose–response relationship. For example, it has been established that for all alcohol-attributable cancers, the higher the consumption of alcohol, the larger the risk for these cancers. (IARC, 2010. Quoted in WHO 2014). Botswana has a total adult per capita alcohol consumption (APC) of 8.4 litres of pure alcohol per annum (5.4 litres recorded consumption and 3.0 litres unrecorded), which is much higher than the Africa region average of 6.0 litres and the global average of 6.2 litres; and third highest in the SADC region, after South Africa with 11.0 litres and Namibia with 10.8 litres (WHO 2014). In 2010 58.5% of the population aged 15 and above had abstained from alcohol in the previous 12 months, 43.6% of males and 73.5% of females, but consumption was extremely high among drinkers with an APC of 20 litres) (WHO 2014; WHO 2011).

3.3.2 TYPES OF ALCOHOL

According to the 2014 Global Status Report on Alcohol and Health, beer accounts for most of the alcohol consumed in Botswana, contributing 56% of total alcohol consumed, wine 12%, spirits 11% and other brews 21%. Chibuku, bojwala and khadi are the most popular non-Western alcoholic beverages consumed (Sebonego 2015).

3.3.3 PATTERNS OF DRINKING

Majority of drinkers in Botswana engage in harmful drinking patterns (Republic of Botswana, 2007). Pattern of drinking reflects how people drink rather than how much they drink. The 2007 Botswana STEPS survey showed that 54.1% of male current drinkers engaged in binge drinking, compared to 51.6% of female current drinkers (Republic of Botswana 2007). Although the STEPS survey does not specify their working definition of the term, binge drinking commonly refers to consumption of large quantities of alcohol in a single session or within a short time, usually defined as five or more drinks at one time for a man, or four or more drinks at one time for a woman (Foundation for a Drug Free World, 2016). This pattern of drinking increases the risks of harm over time.

3.3.4 AGE AND SEX VARIATIONS

Globally, more men than women drink alcohol; more men than women engage in heavy episodic drinking; more men than women are dependent on alcohol; and therefore more men than women suffer the harmful effects of alcohol use (Rehm et al., 2003; WHO, 2011; WHO, 2014; Rossow I et. al, 2013). Harmful alcohol use is the leading risk factor for death in males aged 15–59, mainly due to injuries, violence and cardiovascular diseases (WHO 2014). Men also have much lower rates of abstinence compared to women. In Botswana only 43.6% of males compared to 73.5% of females abstain from alcohol (Ibid).

Drinking among adolescents is also a problem in the country. A study carried out in 2010 revealed that 18.9% of students had had a drink at one or more occasions in their lifetimes (21% of males and 16.9% of females); 37.5% of those who drank had had their first drink before the age of 13; and 53.6% were current drinkers (57% of males and 49.5% of females) (Majelantle, Bainame, Masupu and Nakawana, 2011).

3.3.5 HEALTH EFFECTS AND SOCIO-ECONOMIC EFFECTS

In Botswana as in the rest of the world, alcohol consumption is associated with several health problems including HIV/AIDS, Tuberculosis, cardio-vascular diseases, liver problems, psychiatric conditions and many cancers. Detailed discussions of the association between alcohol and HIV/AIDS, GBV and NCDs will come in the sections that follow. Alcohol also leads to other personal, social and economic problems such as low vocational and educational performance, family breakdown, social disruption, and criminal records.

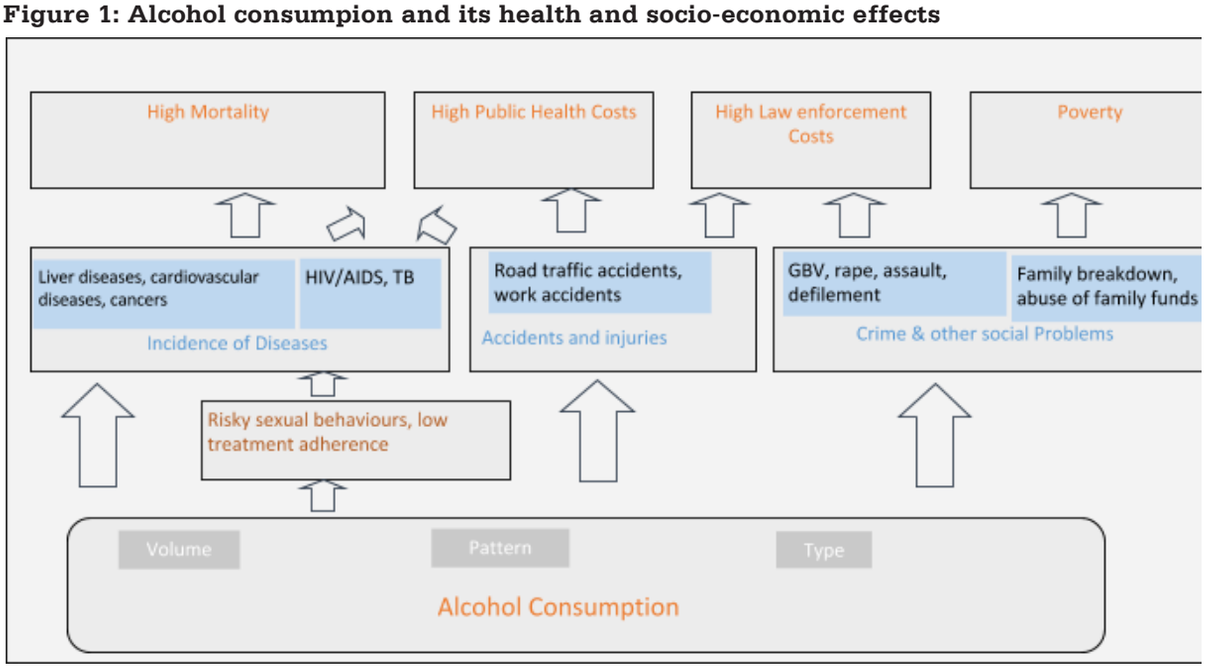
Apart from health effects for the drinker, harmful alcohol consumption has grave consequences for other individuals, for communities and for society at large. Although poverty can lead to alcohol consumption where drinking is used as a coping mechanism, more commonly, alcohol consumption leads to poverty of the individual drinker and his household. As a pricey economic commodity, alcohol uses resources which would otherwise be available for other purposes such as food for the household, school fees for children etc. Where earnings are low, heavy drinking or even any drinking at all may further impoverish the drinker, his household and the community (Schmidt el al., 2010, quoted in WHO 2014). In Botswana where almost 1 in 5 people live below the poverty datum line (World Bank, 2015), the financial strain caused by alcohol consumption cannot be denied.

Alcohol also plays a role in increasing incidents of domestic violence and family breakdown. Heavy drinking has been strongly linked to violence between partners (WHO 2004). In a study conducted in Nigeria, South Africa, Uganda, India, and Colombia a large fraction of reported

domestic violence incidents were shown to be related to alcohol use by the male partner (Green Facts 2016). Evidence in Botswana also shows that there is a strong relationship between alcohol consumption and domestic violence. Programme reports by two leading Women NGOs in Botswana (Kagisano Society Women's Shelter and Women against Rape) have shown that domestic violence, especially intimate partner violence and violence against children are intertwined with alcohol consumption (KSWS, 2016, unpublished; Women against Rape, 2013, unpublished). Increased crimes by youth, road traffic accidents and low productivity at workplaces are other harmful effects also associated with alcohol.

Associated economic problems include low productivity, loss of productivity (due to premature death), law enforcement costs, and direct health care costs. Road traffic crashes, violent crimes, loss of support due to injury or death of the bread-winning drinker and depression are all harmful consequences that affect people around the drinker. Figure 1 below illustrates some of the key linkages between alcohol and public health and socio-economic challenges.

Figure 1: Alcohol consumpion and its health and socio-economic effects



Source: Developed from WHO reports and local literature on alcohol

The above figure shows that alcohol consumption leads to higher incidences of communicable and non-communicable diseases, incidences of accidents and injuries, higher rates of crime and other social problems, which altogether result in higher mortality among the population, increased public health, increased law enforcement costs and higher rates of poverty.

3.4 BOTSWANA'S NATIONAL RESPONSE: A SUMMARY

Botswana has grappled with the problem of harmful alcohol as far back as pre-independence days when various tribal chiefs instituted alcohol restrictions within their jurisdictions (Pitso & Obot 2011). Post-independence, a number of interventions were put in place to address alcohol consumption, including a special Roundtable radio programme in 1981 (Finlay and Jones 1982), the First National Symposium on Alcohol Use and Abuse in Botswana in 1983 (Pitso & Obot 2011) and the enactment of the Trade and Liquor Act of 1986. Several other interventions would be put in place during the decades that followed culminating in the National Alcohol Policy of 2010 and other post-policy interventions.

3.4.1 RECENT POLITICAL AND LEGISLATIVE MEASURES

In recent years the Government of Botswana accelerated its alcohol response particularly to address growing alcohol related harm. In 2003, the Trade and Liquor Act of 1986 was separated into the Trade Act and the Liquor Act to better regulate the sale of alcohol in the country. Unfortunately, the Liquor Act only came into operation in 2008. The Act brought with it the Liquor Regulations that limited access to alcohol by regulating operation hours of alcohol outlets and introducing restrictions on licensing of alcohol businesses.

The Government also introduced the Levy on Alcoholic Beverages Fund Order of 2008 that imposed a 30% tax levy on alcoholic beverages. The tax levy sought to limit access to alcohol by making it less affordable, especially to young people (Pitso, and Obot, 2011). Proceeds from the levy were to be used to finance projects and activities designed to combat harmful alcohol use and reduce its negative consequences (Ibid).

The National Alcohol Policy was introduced in 2010 as an overall framework "to provide a comprehensive guide for priority setting, programme development and implementation, inter-sectoral coordination, and evaluation of effectiveness" of the national response (Republic of Botswana 2010, 2). To give effect to the 2010 policy, Traditional Beer Regulations were introduced in 2011 to regulate the sale and consumption of traditional beverages. Road Traffic (Limit of Alcohol) Regulations were later introduced in 2013 to reduce alcohol related road traffic crashes and improve public safety. The Alcohol and Substance Abuse Division in the Department of Public Health, Ministry of Health was set up to oversee the implementation of the policy and administer the Alcohol Levy Fund. The Division has implemented several programs including educational campaigns, roadshows, publication of names of convicted drunk drivers in newspapers etc.

3.5 THE NATIONAL ALCOHOL POLICY

3.5.1 SCOPE OF THE POLICY

Botswana's alcohol policy focuses strictly on alcohol, and no other psychoactive substances. The country does not have any policy on narcotic drugs and other psychoactive substances, although anecdotal evidence from civil society organizations and the Diamond and Narcotics Squad, indicates that use of these drugs has increased substantially in recent years. The following Table shows Illegal drugs cases handled by the Diamond and Narcotics Squad during the period 2010-2014.

Table 1: Illegal psychoactive drugs cases 2010-2014

Drug	No. of Cases	Quantity	No. of Batswana involved	No. of Foreigners involved
Dagga	2985	3764 kg	4177	198
Cocaine	73	2.0296 kg	104	17
Ecstasy	5	171 tablets	4	3
Ephedrine	10	202.385 kg	0	10
CAT	1	5g	1	0
Heroine	1	4 kg	0	3

Source: Diamond and Narcotics Squad 2015

The above data shows that there is a real drug challenge in the country that may need a policy response in the near future. Poly drug use/ use of more than one drug often involves alcohol as gateway to other drugs. In a 2014 study that sought to examine patterns of drug use and socio-demographic profiles of clients who sought treatment at a substance abuse treatment centre in Gaborone, it was established that 73.08% of clients treated for alcohol reported poly drug use; 80% of those treated for marijuana were poly drug users; and 58.46% of clients treated for nicotine also

reported poly drug use (Selemogwe, Mphele and Manyanda 2014: 46) The study revealed that poly drug users were more likely to report alcohol and nicotine abuse (Ibid).

The limited policy scope is seen by some stakeholders as a serious gap in the country's response to psychoactive substances because it gives the impression that there is no drug problem in the Botswana, which is not the case.

That as it may, a policy that focuses solely on alcohol is not strange, limited or necessarily against international best practise. Some countries have national alcohol policies that deal solely with alcohol while others also combine alcohol and other drugs into one policy. The United Kingdom and the Netherlands, for example, have separate policies for various psychoactive substances while Germany and Norway have integrated policies on psychoactive substances (Muscat, van de Mheen and Barendregt 2010). The choice of the policy approach itself is not nearly as important as the actual integration that has to take place between the alcohol response and the response to other drugs or even other national challenges. Muscat and Pike observe that there should be proper systems for effective policy performance; meaning that, there should be structures and processes in place in a country to enable achievement of the desired policy outcomes (Muscat and Pike 2012). These include proper monitoring mechanisms, political will and integration of the policy into related priority issues. An integrated substance policy still requires coordination in the form of inter-ministerial collaboration, structures and chains of responsibility etc. (Ibid).

The choice to combine or separate psychoactive substances in policy depends on circumstances that prevail. Botswana's drug problem (exclusive of alcohol) is relatively new and less widespread. The alcohol problem on the other hand precedes the country's independence and affects a large proportion of the population directly and indirectly. It is not surprising therefore that a national alcohol policy exists and does not cover narcotic drugs. The focus of the policy is therefore ideal and presents a platform for an optimal response to alcohol that is not compounded by a focus on other drugs.

SDG 3.5 aims to "strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol". As Collin and Casswell observe, "considerable advances in alcohol policy will be necessary to achieve this and other SDG targets, including the reduction of premature mortality from non-communicable diseases by a third by 2030" (Collin & Casswell 2016: 1). Going forward, therefore, the country may need to enlarge the scope of the alcohol policy to incorporate other psychoactive substances, but currently, the more pressing need is to improve implementation of the current policy as is and to build functional institutions and structures to coordinate a robust national response against harmful alcohol use.

3.5.2 INSTITUTIONAL FRAMEWORK

Alcohol response in Botswana Health System

Globally, there is a general consensus that health is the overall central goal of alcohol interventions (Brekke and Sketting (2012); WHO 2004; WHO 2011; WHO 2014). Botswana, in line with this global recommendation, adopts a health perspective in the overall alcohol response. Even though alcohol consumption is admittedly a multi-dimensional problem, the Botswana Ministry of Health bears the overall responsibility to implement an effective inter-sectoral response to harmful alcohol use focused on achieving good health for citizens. In 2010 when the policy was formulated, the Alcohol Consumption Control Unit was moved from the from the Ministry of Trade and Industry to the Ministry of Health (Alcohol and Substance Abuse Division), signalling government's recognition of alcohol related harm as a public health concern.

The Botswana public health system provides integrated health service delivery through various level facilities (hospitals, clinics, health posts and mobile stops) in 27 health districts (Ministry of Health, 2016). Through these structures preventive, promotive and rehabilitative health services as well as treatment and care of common problems (including alcohol related problems) are provided. Services are coordinated through seven departments and functional units (each with specific divisions under it): Department of Corporate Services, Department of Clinical Services, Department of Public Health, Department of HIV & Aids Prevention & Care, Regulatory Services, Health Policy Development Monitoring & Evaluation and Health Hub (Ibid). The Alcohol and Substance Abuse Division, situated in the Department of Public Health "coordinates and develops strategies, programs and interventions for preventing alcohol and substance abuse; and implements programs dealing with excessive drinking impacts and risk behaviours" (Ibid).

The Alcohol and Substance Abuse Division

The Alcohol and Substance Abuse Division has only six officers to oversee the implementation of the National alcohol policy and drive the national alcohol response. The six officers coordinate activities implemented in all the 27 health districts in the country, as well as the NGOs implementing alcohol projects that are funded through the Alcohol Levy Fund. The Division is over-stretched and often cannot cope with the workload, nor can it reasonably be expected to drive a robust and effective national response to alcohol abuse. The Division has no focal person in the districts but it utilizes the Psychiatric nurses stationed in Hospitals and Health Promotion Officers who are part of the District Health Management Team (DHMT). There is a DHMT for each of the 27 health districts in the country.

It is therefore far reaching to expect the Division to marshal sufficient countervailing energy against the challenge of sophisticated alcohol advertising; and at the same time drive public education and awareness; to commission researches and champion effective information dissemination; to support communities and other departments to implement their programs; to coordinate activities of all other stakeholders; to brainstorm, develop and experiment on new alternative measures to address the problem; and to report periodically for proper accountability. Each of the above sample of activities are portfolios on their own that should be resourced adequately if positive results are to be reasonably expected.

Inter-sectoral structures

The inter-sectoral committee is empowered by the national alcohol policy to oversee a national multi-sectoral response to harmful alcohol use in the country. The committee, ideally made up of Directors and Permanent Secretaries is supposed to meet regularly to deliberate on alcohol issues as implemented by the Alcohol and Substance Division. However, the inter-sectoral committee does not meet as regularly as it should, nor does it play its role effectively. The committee has sometimes been inactive. The inter-sectoral committee also seems to have conflict of authority with the Levy Implementation Committee. The latter is a statutorily founded Committee that functions as a Board to supervise utilization of the Alcohol Levy Fund, which generally funds implementation of the policy. The policy, whose implementation is supposed to be overseen by the inter-sectoral committee, is implemented using the Levy Fund, which has a separate body to supervise its implementation. At the end of the day the Levy Implementation Committee approves or disapproves all activities under the policy.

Coordination

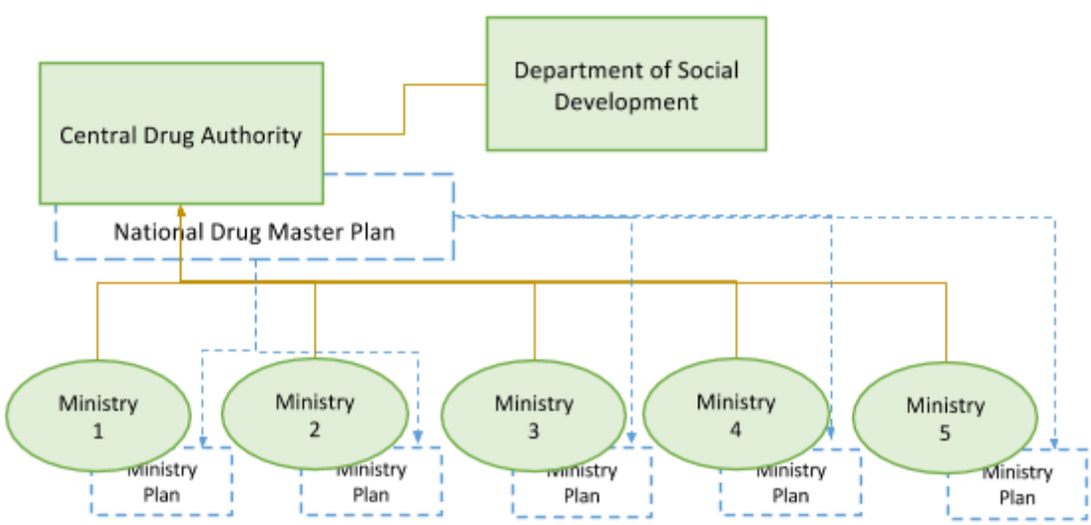
The Ministry of Health (MOH) coordinates the national alcohol response partly because alcohol is globally regarded as a health issue. However, MOH also implements alcohol related activities,

making it both implementer and coordinator of its own activities and the activities of other parallel ministries. Although collaboration is prioritized in the alcohol policy, MOH may lack superior authority over parallel ministries in situations where some decisions have to be made. In the absence of a semi-independent coordinating structure, the alcohol coordinating office would have been better placed at the Office of the President because it is higher in hierarchy than other ministries and so can exercise authority towards them. All the national responses to the other nation-wide problems are coordinated from Office of the President: Poverty Eradication, HIV/AIDS, and Disability. This may give the impression among civil servants that alcohol is a low priority issue that can only be addressed when there is "enough time".

The South African Model

South Africa's institutional structure for the alcohol and drug abuse response has interesting features that can be adapted for Botswana's response. The structure has a Central Drug Authority (CDA), which is an institution created by statute (Prevention of and Treatment for Substance Abuse Act (Act No. 70 of 2008) to assist in the fight against drug abuse in the country. The CDA and its secretariat assist other ministries and departments to implement the National Drug Master Plan (2013-2017). The overall lead department in the campaign against substance abuse is the Department of Social Development which also provides technical and financial support to the CDA and its secretariat as well as developing the legal and policy framework for the response (Republic of South Africa, 2016). Botswana needs a comparative structure that is robust and well resourced. Figure 2 below illustrates the South African model as deduced from official CDA description.

Figure 2: The South African REsponse model



Source: Developed from the Department of Social Development online description available at http://www.dsd.gov.za/

3.6 POLICY PRIORITY AREAS

The National Alcohol Policy has eight key priority areas for action, which, as shall be seen, almost completely shadow the Global Strategy against Alcohol Use. Muscat analysed alcohol polices for 17 countries in Europe and concluded that the common denominator among all the national policies was an over-arching concern with health (Muscat and Pike, 2012). The Botswana alcohol policy is also motivated by health concerns and other negative outcomes of alcohol consumption. The eight priority areas are choices that have been adopted to address the alcohol problem

in the country. However, as some authors rightly observe, alcohol policy choices are often not premised on comprehensive analysis of the problem. Samarasinghe advices that "we must take more trouble to understand how [harmful alcohol use] is generated, maintained and increased; [and] then we can work out ways to minimize it" (Samarasinghe, 2006: 26). A model or scheme of things which clearly dissects the problem, its underlying causes and nuances and delineates possible interventions is necessary before a response can be forged, if that response is to be effective. Whereas global strategies and best practices are useful, they must not replace proper analysis of the problem in the local environment.

The Global Strategy against Alcohol Use recommends 10 policy options and target areas which form the main reference points for analysis of Botswana's policy options. However, a model or technical framework for Botswana's alcohol response is still necessary to build effective, context specific interventions. Apart from two reviews of the Levy on Alcoholic Beverages Fund Order in 2010 and 2012 and a few scholarly articles on alcohol consumption there is no comprehensive literature on nationwide alcohol consumption in Botswana. Some studies on alcohol consumption conducted in the 80s exist but the data is outdated. The acute shortage of literature on the alcohol problem in Botswana is a clear indicator that the problem has not been comprehensively analysed and interventions are not necessarily based on relevant local evidence.

3.6.1 INTER-SECTORAL COLLABORATION

As a priority action area, inter-sectoral collaboration is an important policy choice to address harmful alcohol consumption. Alcohol use is multi-dimensional and cannot be addressed effectively through a single homogeneous structure. The Global Strategy against Alcohol Use prioritizes ***Leadership, Awareness and Commitment,*** charging that national commitments should be "expressed through adequately funded, comprehensive and inter-sectoral national policies that clarify the contributions, and division of responsibility, of the different partners involved" (WHO 2010, 11).

International best practise points out two critical dimensions for measuring fusion of policies and structures, namely structural integration and coherence of strategies and actions (Muscat and Pike 2012). Structurally on paper, the national response is sound because it places the inter-sectoral committee at the centre of its coordination. The committee supervises the overall implementation of the policy.

Table 2: Composition of the Inter-Sectoral Committee

Ministry/ Office/ Organization	Role in the Committee
Director, Department of Public Health	Chair
Alcohol and Substance Abuse Division, Ministry of Health	Secretariat
Ministry of Health (Department of Health Policy Development, Monitoring and Evaluation)	Member
Ministry of Trade and Industry	Member
Ministry of Local Government(Tribal Admin, Social Services, Commercial Affairs)	Member
Ministry of Labour and Home Affairs(Gender Affairs, Department of Occupational Health and Safety)	Member
Ministry of Youth, Sport and Culture	Member
Ministry of Education and Skills Development	Member
Ministry of Defence, Justice and Security	Member

Ministry of Transport and Communications	Member
Ministry of State President (National AIDS Coordinating Agency, Office of Disability Coordination)	Member
Motor Vehicle Accident Fund (MVA)	Member
Botswana Council of Non-Governmental Organisations (BOCONGO)	Member
Botswana Council of Churches(BCC)	Member
Botswana Alcohol Industry Association	Member
World Health Organization	Member

Source: Draft Terms of Reference for the Inter-Sectoral Committee on the Campaign against Alcohol and Substance Abuse, 2015

Relevant ministries and departments are part of the inter-sectoral committee but its terms of reference do not prescribe senior officers for participation. The TORs direct that "the following organisations shall nominate officers to sit in the Committee…" (Republic of Botswana, Unpublished) without setting any standard for the level of the officer that can be nominated. Departments can and do send junior officers who cannot make significant decisions about their department's role in the alcohol response.

Policy coherence

Policy coherence creates synergies between different public policies and leverages capacity to realise a common policy goal. At a minimum, it ensures that different policies do not undermine one another or cancel each other out (Muscat and Pike, 2012). The inter-sectoral committee is positioned to ensure that policies that combat alcohol abuse are coherent with the activities of other government departments. Through the committee, the goal of reducing alcohol related harm must be carried over to all other government functions, including trade, law enforcement, licencing etc. Policy coherence entails cooperation of these departments and bodies to limit availability and thus reduce alcohol consumption in order to give effect to the over-arching goal of protecting public health and safety. With the Inter-sectoral committee occasionally becoming inactive, it is difficult to ensure sustained coordination of alcohol interventions and complementary activities by other functions and departments in Government. The Levy Implementation Committee fills the high level coordinating position and ensures accountability of the Alcohol and Substance Abuse Division in the utilization of funds and implementation of activities and this eases the effect of the occasional inactivity of inter-sectoral committee. Overall, the structure needs to be reviewed to clarify and reconcile the roles of the Inter-sectoral Committee and the Levy Implementation Committee to ensure logical alignment of functions and effective accountability structures.

3.6.2 INCREASING COMMUNITY ACTION FOR SUPPORT

The objective of the second priority area is "to enhance active participation of the community in enforcement of regulations and reduction of alcohol related harm". This priority area mirrors the "community action" recommended in the Global Strategy to Reduce Alcohol. The Global Strategy calls on governments to facilitate recognition of the alcohol problem at community level; and development of locally relevant strategies by the communities; and development of community capacities to implement programmes that limit sale and consumption of alcohol (WHO, 2010). The national alcohol policy recommends similar initiatives at local level. The policy calls for civil society organizations, youth groups, political and cultural groups to develop measures to combat alcohol abuse and for Dikgosi, neighbourhood watch committees and bye-law officers to enforce available legislation on alcohol trade and use. Available literature affirms that communities are

important policy actors with regard to alcohol measures. This priority is therefore ideal and in line with international best practices.

Implementation

Currently there are no programmes that actively engage communities to combat alcohol abuse. The community action espoused in the national alcohol policy involves use of community resources to limit alcohol accessibility, to reduce alcohol related harm and to partner with other stakeholders in the fight against alcohol abuse. However, there are no civil society programmes or government programmes that specifically leverage community resources to lead robust responses to alcohol related harm. The national response therefore does not harness these resources to effectively address harmful alcohol use in the country.

Practical considerations

In leveraging community resources to improve local alcohol responses it is important to recognize that alcohol policy actors overlap with major actors in public health policy, HIV/AIDS policy, trade policy and other policies both at national and local levels. The policy must therefore establish links and interfaces with other strategies, plans and programmes if it is to produce results. This refers to policy coherence as discussed above.

Samarasinghe advices that realities of limited resources and limited capacities at community levels ought to be taken cognisance of when calling for community action (Samarasinghe, 2006:6). The national alcohol policy as well as the national operational plan must therefore be cascaded down to the districts and to individual communities to leverage community resources for a local alcohol response. Districts and communities need to be capacitated to enable them to develop their own action plans that are in line with the national plan.

Community ownership

Success of community action also rests upon community ownership of both the problem and the proposed solutions (Ibid). When communities feel that the problem is not theirs to address or that solutions proposed are not effective, implementation is compromised, and so are results. Pitso and Obot note the public resistance as well as resistance of the alcohol industry to the Alcohol Levy as a measure taken to control drinking, including a motion debated in parliament to have the measure set aside (Pitso & Obot, 2011). Public buy-in can be achieved with aggressive public education about the harm associated with alcohol and the need for drastic measures to control the situation. Public education must therefore inform communities about the harm caused by alcohol to generate improved understanding of the problem and to generate sufficient interest to take action.

National Operation Plan

Coherence must also be built at operational level. A major deficiency of the national alcohol policy is its lack of an operational plan that outlines key actions to be taken by different stakeholders at different levels of government and in communities. As a policy document, the alcohol policy is general and cannot provide clear guidance to various actors to play their roles in the fight against harmful alcohol use. The existing National Strategic Plan to Reduce Alcohol-Related Harm is not detailed to capture actions of various stakeholders at district and national levels and to show how the entire response fits together from lower structures to the highest coordinating office. A national operational plan is therefore necessary. Government ministries and departments can then develop their mini-operational plans basing on the overall national operational plan.

3.6.3 STRENGTHENING PUBLIC EDUCATION AND AWARENESS

The global strategy against harmful alcohol use calls on nation states to ensure broad access to information and effective education and public awareness programmes (WHO, 2010). The national alcohol policy prioritizes integration of alcohol material in the schools curriculums, workplace education forums, youth specific education and nationwide mass education campaigns. Some researchers believe that public education is not an effective measure when it comes to the fight against harmful use of alcohol. In fact, the Global Strategy acknowledges that available evidence is showing little impact of alcohol education. The same Strategy, however, emphasizes the need for public education that "promotes the availability of effective interventions and that mobilizes public opinion and support for effective alcohol policies" (WHO, 2010:31).

Educating communities for positive public opinion and support

As Samarasinghe suggests, people generally know that alcohol causes harm, but they do not know how much harm (Samarasinghe, 2006:6). The public needs to be convinced through education that harmful drinking causes enough harm to warrant drastic measures to be taken to control it. This is necessary to build the right public opinion about the alcohol response. The alcohol response must never be construed to be a preference of a government, or a subjective choice that can be altered at will depending on who occupies positions of power. This appears to be the general view in Botswana, which identifies alcohol measures as an agenda of the current Presidency (Obot, 2014). This view is dangerous and limits public support for the most effective measures against harmful alcohol use. In reality, harmful alcohol use is a serious problem in Botswana that must be owned and addressed by all individuals and communities.

Appropriate strategies

The proposed strategies under this priority area are comprehensive. Integration into the school curriculum ensures early education about alcohol related harm and strategies to address it. The early education is meant to provide sufficient impetus to students to delay initiation of alcohol use. Youth specific education delays initiation of use but also provides necessary education for individual behaviour change among those already abusing alcohol. All major behaviour change theories including the Health Belief Model, the Stages of Change, Theory of reasoned action and even the AIDS risk reduction model hold public education as a central component of behaviour change (Davis et. al, 2014). Mass campaigns proposed in the policy are important to kick-start communities to raise general awareness about alcohol related harm and build public opinion in support of measures taken to combat alcohol abuse.

Current efforts

Currently, the DHMT runs a health education program focusing on anti-alcohol messages. Volunteers hold health talks in schools and in the community while DHMT staff conduct talks in government departments and other forums. One of the assignments for the Ministry of Health under this priority action area is to "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" (Republic of Botswana, 2010). Campaigns have been held but they were wide apart and did not cover all the areas due to the small size of the Alcohol and Substance Abuse Division which coordinates them.

Education at district and community levels

The national policy does not commission districts to engage in active public education in their areas of jurisdiction. Districts and communities must be encouraged to develop public education programs about harmful alcohol use looking at available evidence in their areas. There are some

socio-cultural factors that influence individuals to engage in harmful behaviour after drinking. Some of those factors are built into values of communities. In Botswana a culture of glamourizing alcohol and drunkenness exists and so does alcoholization of social events and activities. Changing such values requires dialogue with communities. The starting point for such dialogue is education about the extent of harm caused by alcohol consumption.

Linking education with research

Public education and awareness must be linked to continuous data collection and research to better understand the problem and inform new ideas (Samarasinghe,2006). Community understanding of the alcohol problem must be continually refined. Research on the trends of drinking and socio-cultural determinants of alcohol related harm needs to be conducted on a continuous basis and results shared with communities. Transparency about new knowledge and new ideas to address the problem is crucial to ensure continued positive public opinion and support for interventions that are effective.

3.6.4 REDUCING HEALTH IMPACTS OF ALCOHOL USE

As a specific policy option, this area focuses primarily on provision of health services for affected individuals and families. The global strategy against harmful alcohol use recommends that member states must increase capacities of their health and social welfare systems to deliver prevention, treatment and care for alcohol-use and alcohol-induced disorders for individuals as well as support for affected families (WHO, 2010). The strategy also prioritises integration of alcohol interventions into primary health care services, including early identification and treatment for harmful users among pregnant women and women of child-bearing age. The SDG agenda 2030 has also incorporated alcohol in its priority areas for action in the next one and half decade, affirming the central role played by alcohol in influencing development or otherwise of the peoples of the world.

Treatment and rehabilitation facilities

Botswana's alcohol policy, in line with these global recommendations, adopts a health perspective in its overall alcohol response. The policy provides for provision of alcohol related services in primary health care, and for special measures to be taken to ensure that the health care environment is stigma-free and confidential (Republic of Botswana, 2010). Whereas the treatment and care environment must indeed be stigma-free and confidential, these policy statements assume existence of treatment and rehabilitation facilities in the country, which are unfortunately a major shortage in the alcohol response. Currently there are only a handful of psychiatric departments in the general health facilities and one psychiatric hospital nationwide. There are also limited out-patient rehabilitation programs run by NGOs. The national alcohol policy therefore needs strong policy recommendations for establishment of treatments and rehabilitation facilities for people suffering alcohol and drug related harm.

3.6.5 ENSURING PUBLIC SAFETY AND AMENITY

Drink-driving policies and countermeasures are some of the most common interventions implemented globally to address alcohol related harm. The Botswana national alcohol policy prioritizes these measures, recommending enforcement of maximum Blood Alcohol Concentration (BAC) limits for drivers as well as public education against drink-driving. To give effect to this policy thrust, the government of Botswana introduced the Road Traffic (Limit of Alcohol) Regulations in 2013 to lower the allowable limit of alcohol content in blood specimen for drivers (with a separate standard for drivers of public vehicles) and introducing stiffer penalties for drink-

driving, among other things. Overall, this is an important policy area to focus on to ensure public safety and reduce road traffic fatalities.

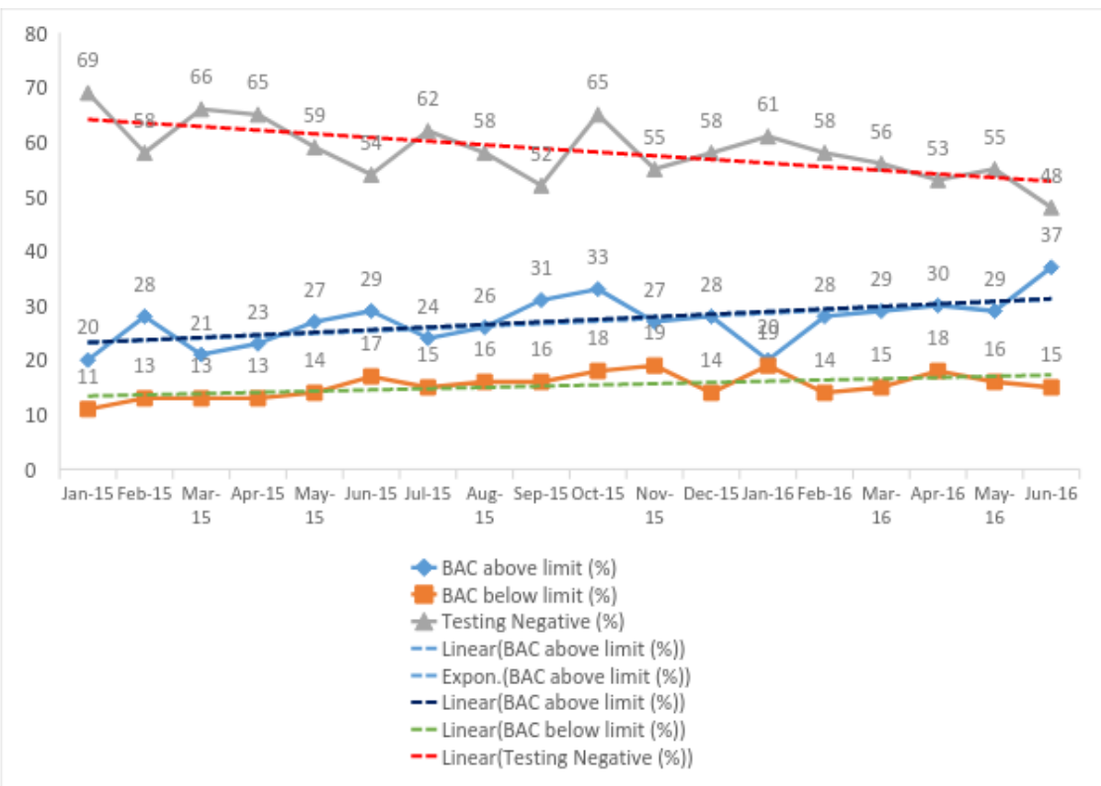
Current measures

Although the Road Traffic Regulations are being implemented across the country, drink-driving is reported to still be a major problem in many districts. Capacity gaps among the police are said to limit extensive enforcement of the regulations. Police statistics indicate that the number of drivers who operate vehicles with above the limit blood alcohol content (BAC) continues to grow steadily. The corresponding number of drivers testing negative on alcohol is reducing over time. The following Table shows the number drivers tested for alcohol content in the blood while driving between January 2015 and June 2016. It is followed by a chart that shows results of BAC tests conducted by the Botswana Police between January 2015 and June 2016.

Table 3: Number of Drivers tested for BAC: Jan 2015 - June 2016

Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Total
1658	1188	2546	2400	1743	1076	1405	1242	1509	1158	1395	1923	1653	1489	1469	866	1055	900	26675

Figure 3: Drivers Alcohol Testing Results January – June 2016 (%)



Source: Botswana Police Statistics

Between January 2015 and June 2016 a total of 26,675 drivers were tested for alcohol while driving. It is interesting to note that in January 2015 only 31% of tested drivers had consumed alcohol, while 69% were alcohol free. By June 2016 more than half of the tested drivers (52%) were driving after drinking alcohol, with 37% driving with a BAC above the legal limit. These statistics demonstrate the need to strengthen enforcement of available laws and to educate the public effectively about harmful alcohol use.

3.6.6 RESPONSIBLE MARKETING

One of the challenges the world faces in addressing alcohol related harm is the influence of the alcohol industry, with all its financial muscle, technology and sophistication. One of the key ways through which the alcohol industry counteracts the alcohol response is marketing of beverages. Naik & Lal (2013) note that alcohol advertising and promotion is rapidly expanding throughout the world and is increasingly sophisticated and carefully targeted, including at youth. "It is aimed at attracting, influencing, and recruiting new generations of potential drinkers despite industry codes of self-regulation that are widely ignored and often not enforced" (Naik & Lal 2013:22). Alcohol promotion techniques include "linking alcohol brands to sports and cultural activities, sponsorships and product placements, and new marketing techniques such as e-mails, SMS and podcasting, social media and other communication techniques" (WHO, 2010: 15).

Alcohol marketing through foreign media

In Botswana, the situation is more challenging due to exposure of the population to alcohol marketing through foreign media and television. The Global Strategy against Alcohol Abuse notes that "transmission of alcohol marketing messages across national borders and jurisdictions on channels such as satellite television and the Internet, and sponsorship of sports and cultural events is emerging as a serious concern in some countries" (WHO, 2010:15). Botswana is one such country. The country has banned all forms advertising of alcohol brands on national television and radio. However, it is difficult to achieve desired results when local viewers of DSTV and other satellite television options are bombarded with multiple alcohol adverts every day. Incorporating a regional focus (over and above locally implemented measures) in the alcohol policy response is therefore a reasonable step to take for Botswana, given its circumstances.

3.6.7 ADDRESSING ILLEGALLY AND INFORMALLY PRODUCED ALCOHOL

The National Alcohol Policy provides for commitments to control illicit production and trade of alcoholic products through legislative and administrative measures. Additionally, it commits the Government to developing measures that provide alternative sources of income to those involved in production and sale of illicit brews. These commitments are aligned to the Global Strategy against Alcohol Abuse, which acknowledges that production and sale of informal alcohol is engrained in some cultures and often need separate control measures from those targeting formally produced alcohol.

Traditional Beer Regulations 2011

To give effect to the national policy, Botswana introduced Traditional Beer Regulations 2011 to regulate the production and trade of traditional beverages. The regulations were important to counter illicit production of highly potent brews that increase risk of harm among consumers, mostly in rural areas. Dikgosi were given authority under the Traditional Beer Regulations to regulate production and sale of traditional beer. However, extensive induction of Dikgosi has not been done to enable uniform and competent implementation of the Regulations.

3.6.8 RESEARCH, NETWORKING AND EXCHANGE OF INFORMATION

The national alcohol policy commissions the Ministry of Health to partner with relevant institutions to generate requisite research to evaluate effectiveness of the policy. The same Ministry is also mandated to "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" (Republic of Botswana 2010:21). However, there is serious shortage of literature on alcohol in Botswana. The limited local content indicates that there are gaps in implementation of the current policy with regard to research and information sharing.

Moreover, where studies or evaluations have been carried out, dissemination of results is weak and needs strengthening.

The Norwegian example

In the Norwegian system, the government has invested in research on substance use by establishing a special research programme and a research centre aimed at clinical substance abuse research to supplement existing research institutes in the field. This was premised on the recognition that existing alcohol- and drug-related data do not provide enough information about the scope of the problem, causes, input of resources and results (Brekke and Sketting, 2012). In the same light, Botswana needs to develop and implement better systems of statistics generation, documentation and reporting in this area. Alongside significantly improving the institution that coordinates the alcohol response, the government should consider establishing a research and knowledge management office focusing on alcohol and drug abuse to ensure better quality of information in this field.

3.7 LINKAGES BETWEEN ALCOHOL AND HIV/AIDS, GBV AND NCDS

There is growing literature revealing strong linkages between alcohol and HIV/AIDS, Gender Based Violence and Non-communicable Diseases (WHO, 2014; WHO, 2010; Weiser et. al., 2006; Majelantle, Bainame, Masupu and Nakawana, 2011; Selemogwe, Mphele and Manyanda, 2014; Leiter KS, et al 2006; Soul City Institute 2008; Republic of Botswana, 2014). The national alcohol policy somewhat discusses some of these linkages, but does not include them in key action areas. This section highlights these linkages and makes recommendations for mainstreaming HIV/AIDS, GBV and NCDs in the Alcohol Policy.

3.7.1 ALCOHOL AND HIV

HIV in Botswana: A brief Overview

HIV is a significant development challenge for Botswana, which has the third highest adult HIV prevalence rate in the world at 21.9%, after Lesotho and Swaziland with 23.4% and 28.8% respectively (AVERT 2016). General HIV prevalence grew from 17.1% in 2004 to 17.6% in 2008 and 18.5% in 2013 (BAIS II, 2004; BAIS III, 2008; BAIS IV, 2013), largely due to the success of the Anti-retroviral treatment and the Prevention of Mother to Child Transmission (PMTCT). Prevalence is higher among females (20.8%) than males (15.6%) and higher in urban areas (19.2%) than in rural areas (17.4%). A close look at BAIS IV results reveals that women are disproportionally affected by HIV, with 16 districts having estimated female HIV prevalence of 20% or more as compared to 4 districts with male HIV prevalence of 20% or more. BAIS IV also reveals poverty, education and unemployment as important socio-economic dimensions that interplay with gender inequalities to increase the risk of contracting HIV. HIV prevalence was estimated at >35% among female day labourers, domestic helpers and those women who never attended school (BAIS IV 2013. Quoted in Republic of Botswana 2013).

Botswana's HIV Response

There has been sustained political, social and financial commitment to respond to the HIV epidemic in Botswana, with the government taking the lead in a number of ways. While the National Policy on HIV and AIDS exists "to provide the general principles by which management of the national response to HIV and AIDS in Botswana is to be guided" (Republic of Botswana 2012), the strategic response to HIV is also based on the National Strategic Framework II (NSF II) 2010-2016 and the National Operational Plan (NOP).

The Role of NACA

The government of Botswana established the National AIDS Coordinating Agency (NACA) in 1999 to mobilise and coordinate an aggressive multi-sectoral national response to HIV and AIDS. NACA is responsible for aligning multi-sectorial efforts towards achieving national and international targets. (Republic of Botswana 2013). The agency was established under the ministry of Health but was later moved to the Ministry of State President with full-fledged ministerial portfolio and mandate (MOH 2016). NACA reports to the National AIDS Council, which in turn reports directly to the Office of the President. At operational level, NACA collaborates with the Ministry of Local Government to ensure that the HIV/AIDS response is decentralized and that it is integrated into District Development Plans. The district actions are harmonized through the District Multi-sectoral AIDS Committees (DMSACs) and the District Development Committees (DDCs). DMSACs coordinate the efforts of various government departments and structures, private sector, civil society and other district level contributors to build unified and targeted district HIV/AIDS responses that are reported through ministerial structures and ultimately to NACA.

Previous achievements and emerging challenges

Botswana's HIV response has largely been successful, especially in the areas of treatment and care and clinical prevention. In 2002 the country launched the MASA programme, an ambitious universal free antiretroviral treatment for all eligible people living with HIV, the first of its kind in sub-Saharan Africa. It was estimated that in 2013, 214,000 adults living with HIV were receiving antiretroviral treatment - a coverage of 69%. (AVERT 2016). Against the backdrop of this remarkable success, Botswana now faces the challenge of sustaining its high-cost response programme in the face of reduced funding and the growing alcohol abuse problem, which has been proven to increase the risk of new HIV infections. Now a middle income country, Botswana has seen many donors decreasing or withdrawing their funding (PEPFAR funding alone decreased by over 30 million US$ between 2009 and 2012 (Republic of Botswana, 2013).

In contrast to successful care and treatment programmes, HIV prevention continues to be a challenge for Botswana. New infections are still high at 9,100 in 2013, down from 15,000 in 2005 (AVERT, 2016). Multiple concurrent partnerships, alcohol, gender inequality and gender based violence, low condom use are key factors driving new infections (Republic of Botswana, 2013).

Linkages between alcohol consumption and HIV/AIDS

Evidence shows that the problems of HIV/AIDS and harmful alcohol consumption are intertwined and need to be addressed in a coordinated fashion. The alcohol policy recognises the linkage between alcohol consumption and HIV/AIDS in its problem analysis. Quoting the National HIV/AIDS assessment for the strategic plan of 2003 – 2009, the policy acknowledges a "correlation between alcohol abuse and high risk sexual behaviours including multiple sexual partners, unprotected intercourse, and the exchange of sex for money or drugs"; and also points out that "for the HIV+ alcohol is associated with delays in seeking treatment, difficulties with drug compliance, and poor HIV treatment outcomes" (Republic of Botswana 2010, 6).

Incomprehensive problem analysis

The correlations highlighted in the policy are real, but the analysis is not sufficiently comprehensive to project the full weight of alcohol consumption's contribution to new HIV infections. A more detailed discussion of the role of alcohol consumption in increasing risk for new infections would paint a complete picture to demonstrate the need to include issues of HIV/AIDS in the policy statements. The centrality of excessive drinking in fuelling new HIV infections needs to be

highlighted to demonstrate that harmful alcohol use is helping to set back the HIV response in the country. It is also worth noting that people can resort to alcohol (or even heavy drinking) to cope with the reality of their HIV+ status.

The NSF II identifies 4 priority areas for the HIV and AIDS response in the country: 1) Preventing New Infections, 2) Systems Strengthening, 3) Strategic Information Management and 4) Scaling Up Treatment, Care and Support. The role played by alcohol in priority 1 is enormous and needs to be clearly articulated, if not in the policy on HIV and AIDS, then more importantly in the national alcohol policy. Such a comprehensive analysis of the problem is necessary to build a case for including HIV/AIDS issues in the alcohol policy priority areas and main action statements. The following Figure illustrates causal linkages between alcohol and new HIV infections, emphasizing the role of alcohol as a catalyst to other key HIV infection drivers.

Figure 4: Alcohol and HIV drivers: an illustration of causal linkages

Illustrating linkages

THE CASE OF KEY DRIVERS OF HIV

The Second Botswana National Strategic Framework for HIV & AIDS 2010–2016 (which is the current national strategic response guideline) identifies alcohol and high-risk sex as one the 5 key drivers of the epidemic in Botswana. The other four are multiple and concurrent sexual partnerships, adolescent and intergenerational sex, stigma and discrimination and gender violence and sexual abuse. Research (as well analysis of the drivers) indicates that alcohol interacts with at least three of the other four key drivers identified to increase the risk of HIV infection as illustrated below. Alcohol is therefore not just a driver of HIV/AIDS by itself but it is a catalyst to others and a central component in the risk of new infections.

Alcohol consumption escalates the HIV risk brought by multiple concurrent sexual partnerships among the population, a key driver of HIV infection. Halperin & Epstein 2004 illustrates that as a predominant sexual behavioural pattern in Southern Africa, including Botswana, multiple concurrent partnerships is an effective driver of HIV due to its network effect. In an MCP context, an individual who has two or three sexual partners is sexually connected to all people that are linked to his two/ three partners and everybody else connected to their partners' partners, forming a dangerous sexual network that can connect a whole community. When HIV or other STI enters into one end of the network, it can quickly move through the entire network and thus affect many people in a short time (Halperin & Epstein 2004). Botswana has an entrenched behavioural culture of multiple concurrent partnerships that helps fuel new HIV infections. Alcohol consumption acts as catalyst to this hazardous situation in two ways. Firstly, alcohol, especially heavy episodic drinking, often results in risky sexual activity with drinking partners or high risk individuals (Leiter KS, et al 2006; Soul City Institute 2008; WHO 2014), thus extending the existing sexual partner networks for the people involved or connecting two existing networks into one larger web. This increases the risk of spreading HIV through a much larger network. Secondly, sexual activity after heavy drinking is often risky and done without use of condoms or with high risk partners (Ibid), further increasing the risk of HIV infection or entry of the virus into the extended network. HIV prevention approaches that address multiple concurrent partnerships need a focused dimension that addresses

alcohol consumption. Conversely, alcohol prevention measures must take cognizance of the role of alcohol consumption in escalating risk of new infections brought by MCP.

Adolescent and intergenerational sex is another driver of HIV (Republic of Botswana 2010) that interacts with alcohol consumption to increase HIV infections. In intergenerational sexual relationships young people- mostly adolescent girls and young women- engage in sexual relationships with older men (sugar daddies) primarily for material gain driven by peer pressure to acquire high-status items or by unemployment and poverty (Soul City Institute 2008). This practice increases the HIV risk for adolescent girls and young women significantly, compared to boys and young men. BAIS IV results show that HIV prevalence among girls aged 15-19 (6.2%) is almost twice the prevalence rate for boys of the same age (3.6%); and the HIV prevalence among young women aged 20-24 (14.6%) is almost three times the prevalence of young men of the same age (5%) (Republic of Botswana 2013).

Studies have shown that early exposure to older men with longer sexual history accounts for the higher infections among adolescent girls and young women, thereby bringing into play intergenerational sexual intercourse as a significant risk factor for HIV infection (Republic of Botswana 2010). Alcohol is a catalyst to this HIV driver in several ways.

The material benefits sought by young women in intergenerational relationships are diverse, but in many cases they include free alcohol during drinking expeditions or at bars and shebeens. Research evidence indicates that young women who visit beer parlours and drinking joints without money often get older, more affluent benefactors who supply alcohol to them in exchange for sexual favours. Due to the imbalances of power in these relationships, young women and girls are often unable to negotiate condom use, thus placing them at much higher risk of HIV infection.

Priority Area focusing on linkages between alcohol and HIV/AIDS, GBV and NCDs

The National Alcohol Policy identifies eight priority areas for action (discussed above), each with policy statements that specify actions to be undertaken by stakeholders to address it. The identified priority action areas are important to address the problem of alcohol. However, a detailed analysis of the role of alcohol in increasing risk for new HIV infections (and analyses of alcohol and GBV and NCDs below) demonstrates the need to incorporate a priority area focusing on linkages between alcohol and HIV/AIDS, GBV and NCDs. Commitments to incorporate alcohol measures in interventions against HIV/AIDS, GBV and NCDs must be elevated and clearly articulated among alcohol policy priorities. Samarasinghe identifies linkages with department and agencies in "allied" fields as one of the key elements of successful national responses (Samarasinghe 2006).

Alcohol must be addressed in the other policies

Alcohol is not only a common denominator in the three identified national challenges, but it is also a causal factor for each of them. Policy and strategic measures targeting each of these problems must address alcohol as a causal factor. Coherence of the alcohol policy and policies on HIV/AIDS, GBV and NCDs must be achieved both at policy concept level and operational levels.

3.7.2 ALCOHOL AND GBV

Gender Based Violence in Botswana: An Overview

Gender based violence, especially violence against women and children, is pervasive in Botswana. In March 2012, Gender Links Botswana and the then Women Affairs Department (now Gender Affairs Department) completed a Gender Based Violence Indicators Study, which revealed that 67% of women had experienced some form of gender based violence in their lifetime, including partner and non-partner violence. 29% experienced Intimate Partner Violence (IPV) in the 12 months immediately preceding the study but only 1.2% of women reported cases of GBV to the police in the same period (Gender Links 2012). GBV is directly influenced by alcohol consumption and it also increases victims' risks of HIV infection (Sinkamba 2015; Republic of Botswana 2012; Pitso JN & Obot IS 2011; WHO 2010; WHO 2014).

Response to GBV in Botswana

Botswana's response to GBV (which disproportionately affects women) is part of a larger agenda to empower women in all spheres and to eliminate violence against women and children. The country promulgated its National Policy on Women in Development in 1996 to address the situation of women in an integrated and multi-sectoral manner (Republic of Botswana, 1996). The government of Botswana also elevated the National Women's Machinery to a fully-fledged government department, the Women Affairs Department in 1996/97 (now Gender Affairs Department). A new National Policy on Gender and Development was introduced in 2016 to guide interventions related to gender, gender equality and development (including gender based violence). Empowered and guided by these instruments, The Gender Affairs Department, housed in the Ministry of Labour and Home Affairs spearheads government's work on gender related issues.

Apart from law enforcement, there are no Government structures that focus directly on gender based violence as a national problem. The phenomenon mostly manifests as a crime and is dealt with by the Police and the courts with the aid of critical legal instruments such as the Domestic Violence Act, the Children's Act, Abolition of Marital Power Act etc. The Gender Affairs Department deals with broad issues of development as they affect women and is mostly focused on economic empowerment and advocacy. GBV occurs predominantly in the private sphere and

is rooted in people's cultural norms, beliefs and traditions, especially in rural areas, making it impossible to comprehensively address without matching legislative and policy interventions (championed by government) with on-the-ground programs (led mostly by NGOs). NGOs are therefore an integral part of the response against GBV in Botswana.

Linkages between alcohol and GBV

The World Health Organization's report on Global and Regional Estimates of Violence against Women records that harmful alcohol use and violence are intertwined. The report shows that alcohol is not only a facilitator of men's use of violence against their intimate partners and children but women who frequently drink alcohol also have higher chances of being abused (WHO, 2013). Alcohol also acts as a catalyst to gender based violence and the resultant increased vulnerability to HIV.

Isolation of national problems

Apart from a single reference, the National Alcohol Policy is silent on GBV throughout its problem analysis and priority action areas. A comparative analysis of the National Alcohol Policy and the National Policy on Gender and Development shows that the two polices address two phenomena that seemingly have little in common. The National Policy on Gender and Development refers to 'alcohol' only once in its entire text, and the National Alcohol Policy similarly makes reference to gender based violence only once in its entire discussion. The weak discussion of the association between alcohol consumption and GBV in both policies controverts extensive evidence linking the two.

Intoxication and violence

Empirical evidence has shown that people who drink to intoxication are more likely to become violent, both in the public sphere and more probably against family members in their homes (Naik and Lal 2013; WHO, 2013). In a study that investigated the link between alcohol, gender based violence and HIV/AIDS in Botswana Phorano et al concluded that a causal relationship exists between alcohol abuse and gender-based violence, which makes victims vulnerable to HIV infection (Phorano et al 2005). The violence maybe sexual, physical or emotional, thus further weakening the position of the women involved as well as their ability to negotiate safer sex.

It is important to note that alcohol abuse is not only a major facilitator of GBV (cause) but can also be a coping mechanism for victims of GBV (effect). Alcohol must therefore be addressed as a problem that disrupts family peace, influences violence and perpetuates child abuse. These subjects must not be foreign to the alcohol campaign but must find expression in both the alcohol policy and the policy on gender and development. Policy options that emphasize confidential and client-friendly services at community level must be prioritized to encourage clients to seek assistance and be more open about their drinking patterns and the abuse they suffer or perpetrate.

A priority area on linkages

The national alcohol policy and the policy on Gender and Development both have gaps in that they fail to address linkages between alcohol and GBV. SDG 5.2 aims to "eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation" (Ibid). The national alcohol policy as well as the national policy on gender and development will need to be strengthened to capture linkages between alcohol consumption and violence against women and girls. The elimination of violence against women espoused by the SDGs can only be possible if determinants of GBV and/or VAW such as

excessive drinking are addressed. As discussed above the national alcohol policy needs to have a clear priority area on linkages between alcohol and HIV/AIDS, GBV and NCDs to pronounce focused policy commitments that will ensure coherence in the responses against alcohol, HIV/AIDS, GBV and NCDs.

3.7.3 ALCOHOL AND NCDS

NCDs in Botswana: an Overview

Botswana has an increasing burden of non-communicable diseases. According to a World Bank Report NCDs accounted for 14.5% of total mortality in Botswana in 2000, increasing by more than 100% in 10 years to 32.5% in 2010 and 36.8% in 2012 (World Bank; quoted in Index Mundi 2016). The most prevalent NCDs in Botswana are cardiovascular diseases, which accounted for 18% of total deaths across all age groups in 2012 (WHO, 2014). In the same period, various cancers accounted for 5% of total deaths, diabetes 4%, chronic respiratory diseases 2%, while other NCDs were responsible for 8% (Ibid). The African Health Observatory (AHO) reports that before 1980, infectious diseases and those associated with unsanitary conditions, poverty and inadequate hygiene were the most common in Botswana. With the discovery of diamonds and increase in wealth, new patterns of conditions associated with affluent lifestyles such as hypertension, diabetes and cardiovascular diseases emerged after 1980, although the full weight of NCDs is overshadowed by infectious diseases such as tuberculosis and HIV/AIDS (African Health Observatory, 2016). A survey carried out in 2009 on people aged over 50 years in Botswana revealed that 67% had hypertension while 12.3% had diabetes (Quoted in AHO 2016). Major risk factors to NCDs in Botswana include excessive alcohol consumption, smoking, excess weight, poor diet, and low physical activity/ exercise (Republic of Botswana 2007; AHO 2016; WHO 2014).

The 2007 Botswana STEPS survey indicated that 1 in 5 people in the population currently smoke; 54% of current male drinkers and 51.8% of female current drinkers engage in binge drinking; 72.7% do not engage in vigorous physical activity(59.5% of males, 84.2% of females); and 38.6% are overweight (53.4% of females and 22.1% of males) (Republic of Botswana 2007). With this web of risk factors interplaying in the population, it is not surprising that over 6000 people died because of NCDs in 2008 (WHO Statistical Information System 2012, Quoted in Statistics Botswana, 2013).

Response to NCDs in Botswana

Botswana has no operational multi-sectoral national policy, strategy or action plan that integrates several NCDs and shared risk factors. NCDs are addressed as part of the regular primary health services regulated by the Health Policy and other general health regulatory instruments.

Non-communicable diseases are integrated into primary health care in Botswana, with clinics and hospitals addressing majority of the conditions including, hypertension and diabetes etc. However, there are few specialised facilities dealing with more complicated conditions such as cancers and other cardio vascular diseases. The burden of NCDs on public health expenditure is enormous.

Linkages between alcohol consumption and NCDs

Evidence has shown that alcohol is a major contributor to a variety of NCDs including cardiovascular diseases, cancers, liver cirrhosis etc. (Naik & Lal, 2013). The Global Status report on Alcohol and Health lists the following categories of NCDs that are causally impacted by alcohol consumption:

neuropsychiatric conditions (epilepsy, withdrawal-induced seizures, depression or anxiety disorders); gastrointestinal diseases (liver cirrhosis, pancreatitis [both acute and chronic]); cancers (cancer of the mouth, nasopharynx, other pharynx and oropharynx, laryngeal cancer, oesophageal cancer, colon and rectum cancer, liver cancer and female breast cancer); and cardiovascular diseases (hypertension, atrial fibrillation and haemorrhagic stroke) (WHO 2014:12).

In its problem analysis, the National Alcohol Policy discusses linkages between alcohol consumption and non-communicable diseases, especially mental health related conditions. The policy finds associations between some psychiatric conditions and consumption of certain homebrews, some of which have since been declared illicit and illegal by the Traditional Beer Regulations of 2011.

NCDs are addressed in the policy

The national alcohol policy somewhat addresses the effect of excessive drinking on incidences and severity of NCD without necessarily discussing the linkages in detail. Priority area for action 4.5 in the policy (Reducing the health impacts of alcohol abuse) to a large extent addresses NCDs particularly because they are intimately integrated into primary health care. By focusing on "those who drink for intoxication" and the "long-term heavy drinkers", the policy addresses issues of volume as well as patterns of consumption, which have been proven to impact directly on the health of alcohol users (WHO, 2014). The policy also addresses illegally and informally produced alcohol, which has been identified as an important factor in influencing adverse health consequences for drinkers.

Clinical data on alcohol as component cause of NCDs

SDG 3d is a commitment to increase the capacity of all countries for early warning, risk reduction and management of national and global health risks. When this commitment is applied to the global and local burden of alcohol-related harm (especially as regards NCDs and HIV/AIDS), effective policy responses for reducing and managing risk will require explicit recognition of alcohol as a key health risk that needs to be addressed aggressively. There is need, therefore, for a policy statement that calls for collection of cross-sectional clinical data on the contribution of alcohol to NCDs addressed in health facilities across the country. The policy statement can be placed under priority area Research and Information sharing.

4 SUMMARY OF POLICY GAPS

4.1 INTER-SECTORAL COLLABORATION

- The policy does not pronounce on the composition of the inter-sectoral committee in terms of the required level of authority of its members. It requires the Government to strengthen the committee by formalising its terms of reference but the TORs alone are not sufficient to empower the committee to provide effective "strategic guidance, coordination and supervision of the national policy". The inter-sectoral committee's authority is therefore too limited to build coherence between the alcohol policy and other activities of government such as licensing procedures for liquor outlets.

- The policy does not address the institutional requirements to coordinate its day to day implementation. The result is that the Alcohol and Substance Division, which is mandated to deal directly with alcohol related harm, lacks sufficient capacity (primarily in terms of number of personnel) to drive a robust alcohol response that the country desperately needs. With only six officers at national level and no structures or representatives at district level, the Division is too small, given the magnitude of the alcohol problem and the complexity of socio-economic, cultural and other factors underlying it.

4.2 INCREASING COMMUNITY ACTION FOR SUPPORT

- The policy does not provide for integration of the anti-alcohol response into district and community structures. Even though it prioritizes community action, the policy assumes that communities will initiate actions on their own and collaborate with various agencies such as police and Bye-Law offices to enforce response action without a focused, targeted coordinating structure. In the response against HIV/AIDS, the AIDS coordinating office (District AIDS Coordinator and other staff) mobilizes various players to participate in the fight against HIV/AIDS including government departments, civil society organizations, religious organizations, tribal administration and their sub-structures. The response against poverty eradication also has dedicated district officers to engage stakeholders at district and community levels and to coordinate activities. Such district level and community level coordination is lacking in the alcohol response. The national response should therefore be cascaded down to lower structures of government, both central and local government.

4.3 STRENGTHENING PUBLIC EDUCATION AND AWARENESS

- The policy rightly provides for mass campaigns championed by the Ministry of Health to educate the public about alcohol abuse. However, the lack of clear representation of Alcohol and Substance abuse division at district level means that such campaigns are coordinated at national level. The country is vast and has multiple districts. To sustain the momentum of districts and communities to effectively respond to alcohol related harm requires frequent engagement of those districts and communities, which cannot be done adequately from a national office.

4.4 REDUCING THE HEALTH IMPACTS OF ALCOHOL ABUSE

- Commitments to improve the environment in which treatment is given for alcohol related harm must be accompanied by similar commitments to establish or improve treatment and rehabilitation facilities for alcohol related harm. In Norway, treatment is the state's responsibility, care services and prevention the responsibility of the municipalities" (Brekke and Sketting, 2012). Botswana also needs to invest in provision of treatment and protection of people with alcohol use problems.

4.5 RESEARCH, NETWORKING AND EXCHANGE OF INFORMATION

- The policy recommends a single comprehensive study on the production and consumption of alcohol in the informal sector instead of continuous data collection. Commitments to engage communities to respond aggressively against alcohol abuse require continuous refinement of knowledge through collection of data on production and consumption of alcohol in both formal and informal sectors.

4.6 LINKAGES WITH HIV/AIDS, GBV AND NCDS

- The policy adopts a problem isolation approach rather than an integrated response mechanism. Linkages between alcohol and HIV/AIDS, GBV and NCDs are not adequately explored and emphasized in the alcohol policy. There is need for a policy thrust to address these linkages and to commission active collaboration and mainstreaming of alcohol issues into the other policies and strategic responses. The HIV/AIDS policy and the policy on Gender and Development do not address alcohol and Botswana does not have a specific policy focusing on NCDs. These problems therefore are addressed in isolation although practically they are inter-linked, especially with alcohol as a common factor. As a cross-cutting causal factor in these national problems alcohol can be more effectively mainstreamed into the responses against those problems over and above having the policy on alcohol addressing those issues specifically. The alcohol policy should therefore highlight the linkages and provide for mainstreaming of alcohol in the responses against HIV/AIDS, GBV and NCDs.

PART TWO

5 STAKEHOLDER CONSULTATIONS

5.1 METHODOLOGY

Part two covered stakeholder consultations in Gaborone and selected districts to solicit their views and input into the review and to widen perspectives on the multi-sectoral approach adopted for the alcohol response. Semi-structured key-informant interviews were conducted with government officials in key departments (social welfare, public health, local government, and police), community leaders (chiefs, VDC chairpersons and pastors) and programme implementers in the civil society. Key-informants were selected purposefully, targeting departments and institutions that play a key role in the alcohol response and/or HIV/AIDS, GBV and NCDs responses. The following Table summarizes the number of interviews conducted.

Table 4: Interviews Conducted

Category	Department/ Area	No. interviewed	Interview Type
Government Departments	Social Welfare	2	Individual interviews
	Public Health (District AIDS Coordinator, District Health Management Team, DAC M&E Officer)	6	Individual Interviews
	Alcohol & Substance Abuse	1	Individual interview
	Local Government (District Commissioner)	3	Individual interview
	Individual interviews Police	2	Group interview
	Gender Affairs	1	Individual interview
	Ministry of Youth Empowerment, Sports and Culture Development	1	Individual interview
	Ministry of Basic Education	2	Individual interviews
Civil Society	Women Against Rape	2	Group interview
	Botswana Substance Abuse Support Network	3	Group interview
	Kagisano Society Women's Shelter	1	Individual interview
	Botswana Council of Churches	2	Group interview
	Gender Links	1	Individual interview
Tribal and Religious Leaders	Dikgosi	2	Individual interviews
	Village Development Committee	8	Group interviews
	Pastors	1	Individual interview

Specific guiding interview questions were developed for each of the three categories (government departments, civil society and tribal and religious leaders). For government officials and civil society representatives, a meta-policy approach was adopted, focusing on the systems and overall context of the alcohol response. The two broad groups were asked about political, economic and socio-cultural factors influencing both the alcohol problem and the selected solution in the policy

as well as how response structures at national and district levels were organized in the alcohol response. Questions for tribal and religious representatives focused more on their ascribed roles and functions in the alcohol response, gauging capacities and competencies as well as buy-in into the broad national alcohol response. Interview guides are annexed hereto.

Most government officials were interviewed individually by virtue of the positions they held in their departments. Civil society organizations each delegated more than one representative for interviews, except where there was only one officer in the district or town. Village Development Committees were interviewed in groups to complement each other's competencies on the subject.

Key-informants were interviewed in Gaborone and six other areas. Gaborone was selected because of its strategic position as the capital and because a number of key-informants in government, religious groups and NGOs were based in the capital city. The other six towns and villages were selected based on their spatial positioning in the country, to get a balanced representation of the views from the different regions of the country. Molepolole was selected as the most populated urban village in the country and to represent the Kweneng district; Goodhope represented the far south of the country; Ghanzi represented the Kgalagadi region; Maun represented the west of the country; Sebina represented the north; and Mahalapye represented the central. Although harmful alcohol use is a common problem across the regions of Botswana, interviews were expected to highlight some geographical peculiarities and diversities of practices, cultural norms and perceptions about alcohol, GBV and HIV/AIDS.

5.2 THE ALCOHOL PROBLEM: ITS NATURE AND FORM

The extent of Harmful alcohol consumption

The general view among stakeholders is that the alcohol problem has reached pandemic proportions in the country. Some public service providers have concluded that almost every individual in the country has a relative, a friend or a colleague that is drinking excessively or struggling with alcohol. Harmful alcohol consumption is therefore a real problem in Botswana and its effects are felt across all districts in the country.

Problem Dynamics

Stakeholders were asked to describe how the alcohol problem presents itself in their communities and the general conclusion was that the problem manifests differently from one community to another. In Gaborone, Molepolole, Maun and other places with thriving economies, the working class drink modern beers and spirits daily, and drink to intoxication on weekends (Friday, Saturday and Sunday). Common practices include converging at bars after business hours, parking cars in in open spaces to drink leisurely during weekends, drinking in car parks outside bars and clubs after they close and drinking excessively at parties during weekends. In these affluent towns and urban villages population segments with low income also drink traditional beers excessively (mostly chibuku). In poorer neighbourhoods across all target districts excessive drinking cuts across the sub populations, with the majority of the drinkers spending their whole days at shebeens, drinking local brews and chibuku. In small villages and settlements, where most of the people are unemployed, continuous drinking is reported to be virtually the only activity that most people engage in. In settlements and cattle posts salaries of herdsmen all go to alcohol by default, leaving little or nothing for other needs.

Although certain alcohol outlets are associated with specific sub populations and groups, men, women and youth are all reported to drink to harmful proportions. In all places adolescents are reported to be indulging in alcohol consumption very early, sometimes as early as 13 years old. In Maun and other places young people have specific drinking spots and clubs (an example being the Freshers Exclusive Club, Maun), where underage drinking is common. In Ghanzi and other places where many people are unemployed, majority of people are reported to commonly drink traditional brews. The legal traditional beers are frequently modified to increase the alcohol content without changing their usual appearance.

Common Effects

The most common effects of alcohol consumption reported in all districts include rape, theft, robbery, road traffic crashes, child neglect and other aggressive and violent behaviours. Violence is reportedly more common among younger populations (mostly 20-30) than among elderly people drinking traditional beer. Even so, more aggressive and violent behaviours are experienced at shebeens and depots (chibuku) than at bars.

5.3 WHY DO PEOPLE DRINK EXCESSIVELY?

All stakeholder were asked to express opinion on why people drink excessively. Among Village Development Committee members who were interviewed in groups, this generated a discussion about possible reasons for drinking excessively. Other stakeholders, interviewed either individually or in pairs also gave their opinions on the question. The following reasons were the most common among the 38 key-informants interviewed.

Weak law enforcement: Most stakeholders noted that law enforcement in relation to excessive drinking was weak in their areas and was a critical factor in influencing excessive drinking. Opening and closing hours of bars and shebeens are largely not observed in many areas. Drinking starts early in homes and often leads late into the night. Legal restrictions on the density of alcohol outlets, the distance of bars from schools, churches and highways etc. are often not enforced, even for new establishments being licensed.

Public Events and activities: Alcohol consumption is associated with most public events such as soccer matches, weddings, music festivals, and other sporting activities. On paper, regulations ban alcohol at some of the events such as state sponsored constituency tournaments and art competitions but stakeholders have noted that alcohol is still a central part of these events. A culture of drinking is built in the population when public events are synonymous with alcohol consumption.

Degraded social values: Social values that would sanction most behaviours linked to excessive drinking have reportedly been replaced by new values that promote harmful alcohol consumption. Public indecency such as walking in the streets with beer in hand, urinating in open spaces, staggering from over-drinking or throwing insults after bouts of intoxication are regarded as normal by other members of the community. These behaviours do not attract enough shame and social sanctions to deter individuals from doing them. Children are socialised into this value system and perpetuate it as they grow up.

A culture of drinking: Stakeholders reported that a culture of drinking exists in their communities and is widely accepted. Drinking is a customary activity across the country, especially during weekends. Intoxication is branded as excitement or as a sign of freedom and enjoyment of life or a

status symbol. Presenting drinking to appear normal and exciting contributes to higher numbers of young people who choose to drink when they attain the legal age of drinking.

Unemployment: In especially low income, high-density areas and in small villages, the majority of people are reported to be drinking because they are unemployed and have nothing else to do. They resort to alcohol in order to contain the frustration and deep stress of unemployment.

Lack of alternative entertainment: People reportedly drink alcohol (excessively) because they do not have anything else to do for leisure. With no amusement parks in the country, limited number and limited quality of public parks, limited sporting facilities in most places, people often have nothing to do with their free time except to gather together for alcohol.

5.4 THE CURRENT RESPONSE: NATIONAL ALCOHOL POLICY

5.4.1 SCOPE OF THE POLICY

The national alcohol policy focuses solely on alcohol and not on other psychoactive drugs. This limited policy scope is seen by some stakeholders as a serious gap in the country's response to psychoactive substances. Alcohol is reported to be the gateway into other drugs, which are often harder and illegal, and are increasingly being used in the country. The causal linkages between alcohol and public health challenges such HIV/AIDS and NCDs also apply to harder drugs, and sometimes are more pronounced and much more detrimental.

5.4.2 INSTITUTIONAL FRAMEWORK

Stakeholder consultations revealed that the institutional framework to drive the national alcohol response is weak and cannot adequately address challenge as complex as alcohol abuse in Botswana. The Alcohol and Substance Abuse Division has only six officers to oversee the implementation of the National alcohol policy and a drive the national alcohol response. The Division is over-stretched and often cannot cope with the workload, nor can it reasonably be expected to drive a robust and effective national response to alcohol abuse.

5.4.3 NATIONAL ALCOHOL POLICY KEY PRIORITY AREAS

Inter-sectoral collaboration

Stakeholder interviews showed that service providers implementing alcohol programs or providing alcohol related services are isolated and lack functional collaboration. There is limited coordination of activities targeted at reducing alcohol abuse in all areas. Districts do not have Alcohol focal persons and this makes it difficult to coordinate any alcohol related activities. In some districts there are Anti-Alcohol Committees made up of different stakeholders in government and civil society but the committees meet irregularly and often do not implement any activities. Committees working in Poverty eradication, Disability or HIV/AIDS (DMSACs) are reported to be effective largely because there are focal persons or offices championing activities at district level. The Police, Bye-Law officers, psychiatric nurses, health promotion officers all carry out alcohol related activities as part of their core mandate, but with little networking and collaboration among themselves or with other service providers. For example, the Police should be able to recommend to the Liquor Licensing Committees to suspend, revoke or not renew licenses of businesses which constantly contravene regulations on liquor trade. However, that collaboration is non-existent. Enterprises that repeatedly violate conditions of their licences go unpunished because the licencing committees do not work hand in hand with the law enforcement agencies (the Police and Bye-Law) and this weakens the national alcohol response.

Community action

Although this is a critical priority area in the policy, on the ground there are no programmes that actively engage communities to combat alcohol abuse. The Police acknowledged that members of the public report nuisance cases related to alcohol, but the community action espoused in the policy involves use of community resources to limit alcohol accessibility, to reduce alcohol related harm and to partner with other stakeholders in the fight against alcohol abuse. There are no civil society programmes or government programmes that specifically leverage community resources to lead robust responses to alcohol related harm.

Public education and awareness

The DHMT runs a health education program focusing on anti-alcohol messages. Volunteers hold health talks in schools and in the community while DHMT staff conduct talks in government departments and other forums. In Ghanzi, for example, there are 2 volunteers at each of the 3 clinics in the town and 1 at each of the 9 health posts in the district. All stakeholders in all districts were aware of the public education by Substance Abuse Volunteers.

Reducing health impacts of alcohol

Counselling services for alcohol related cases is recommended in the National Alcohol Policy but is generally unavailable in primary health care. Intensive one-on-one counselling and other services are only provided in limited cases of severe effects such as alcohol related mental problems. The Social Welfare department is also mentioned in the policy as one of the possible providers of counselling services for alcohol related cases. Interviews with social workers revealed that the department, although well placed to provide such counselling, is not resourced sufficiently for it. Some NGOs such as Women against Rape (WAR) in Maun and Botswana Substance Abuse Services Network (BOSASNET) in Gaborone do provide alcohol related counselling and rehabilitation. The two organizations provide out-patient rehabilitation and other interventions for people with alcohol problems ranging from unhealthy drinking habits to alcohol dependency. However, they also have resource challenges that inhibit wider service coverage. WAR, for example, utilizes trained Substance Abuse Counsellors who are currently volunteering daily to assist clients since there is no funding for a full programme.

Public safety

Although the Road Traffic Regulations are being implemented across the country, drink-driving is reported to still be a major problem in many districts. Capacity gaps among the police are said to limit extensive enforcement of the regulations.

Responsible Marketing

Most stakeholders agreed that marketing of alcohol is minimal in their areas. Except for a few Name Boards for bars and clubs, there are generally no blatant marketing of alcoholic beverages through regular avenues. National television and Radio have banned alcohol advertisement. However, stakeholders acknowledged that foreign television floods local viewers with constant persuasive advertisement of alcoholic beverages that seek to initiate new young drinkers or maintain interest among regulars.

Illegally and informally produced alcohol

Dikgosi have been given authority under the Traditional Beer Regulations of 2011 to regulate production and sale of traditional beer. Members of the community are supposed to alternate on brewing traditional beer, each with permission from Dikgosi. Interviews with Dikgosi revealed that they have varying competencies to implement Traditional Beer Regulations. Some

expressed difficulty to enforce the regulations since they do not have a clear schedule of offences and corresponding penalties while others acknowledged a specific schedule of offences and accompanying penalties.

In some areas brewers of traditional beer do not report to Dikgosi or Dikgosana and they do not open at 2 pm as provided in regulation. With no designated watchdog groups to monitor alcohol activities in the community, Dikgosi are often unaware of the illicit brewing that goes on in people's homes. Before they were redeployed to work directly with the Police and to report to Police Stations, crime prevention teams (commonly called Cluster Groups" assisted Dikgosi to monitor their communities and to identify law breakers. Dikgosi now have limited resources to monitor their communities and to effectively enforce the Traditional Beer Regulations.

Research and networking

There is very little research being conducted on alcohol consumption in the country. Stakeholders were generally not aware of any previous, ongoing or planned studies in their areas. However, the nature of the alcohol problem requires continuous research to facilitate implementation of evidence-based programs.

5.4.4 LINKAGES BETWEEN ALCOHOL AND HIV/AIDS, GBV AND NCDS

Stakeholders generally articulated critical linkages between alcohol and HIV/AIDS as well as between alcohol and GBV. However, NCDs were not part of the common language of most stakeholders and they did not appear to fully understand the role played by alcohol in causing NCDs.

Most stakeholders were able to note that alcohol impairs decision making including decisions about sexual activity. They explained that people often engage in unsafe sex when they are intoxicated and this increases chances of HIV infection and other STIs. In Gaborone alone it was reported that over 20 000 cases of STIs were recorded in 2015. That represented over 20 000 chances of spreading HIV from one person to another.

Majority of the stakeholders had never seen or read the national alcohol policy. It was therefore impossible to ask them about the linkages between alcohol, HIV/AIDS, GBV and NCDs as articulated in the policy.

5.5 VIEWS, CONTRIBUTIONS AND CONCLUSIONS OF KEY STAKEHOLDERS

The following sections summarize the roles, views and recommendations of various categories of stakeholders.

5.5.1 POLICE- LAW ENFORCEMENT

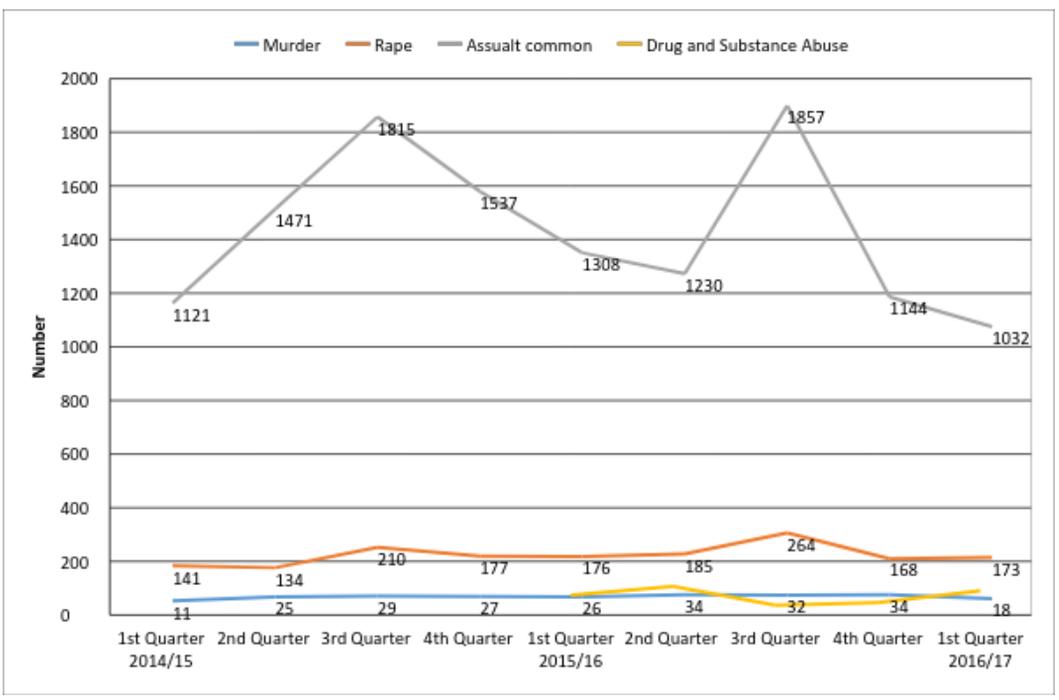
The following summary was drawn from 2 sources, an interview with Mahalapye Police and a Botswana Police report on alcohol related legislative measures.

Role of the Police: The Police generally enforce the Liquor Act and other statutory instruments related to alcohol production and consumption in collaboration with Bye-law officers and Dikgosi. However, the police are often thin on the ground and have limited resources (such as transport), especially during the night when Bye-law offices and Dikgosi do not operate.

Alcohol related offences: Police statistics indicate a general decline in the number of alcohol related offences, except consumption of liquor in prohibited areas. There are new trends of sale of liquor without a licence, especially at bars and clubs after closure of liquor outlets. These new trends of sale of liquor without licences are new ways of circumventing legal restrictions on accessibility of alcohol.

Penal code offences associated with alcohol: Evidence shows fluctuating rates of penal code crimes associated with alcohol. Although there are no clear increases in the crimes, the rates are still high for a small population of just over 2,000,000. The following Table summarizes penal code offences committed between April 2014 and April 2016.

Figure 5: Some Penal Code Offenses Associated with Alcohol Consumption



Source: Botswana Police Statistics

5.5.2 SOCIAL SERVICES

This summary is drawn from interviews with social workers in Goodhope and Sebina.

Alcohol related harm: Social services personnel indicated that majority of cases of rape, child neglect, defilement and other violent crimes had an alcohol component. There are other social problems in the districts, such as family breakdowns and poverty but alcohol is usually an important contributor to each.

Counselling: The social workers do address alcohol related matters, but not directly. In many cases alcohol is a component of the main issues being dealt with such as defilement, or child neglect. Capacity constraints prevent the social welfare officers from making targeted outreaches and addressing alcohol related issues in-depth. In Goodhope sub-district, for example, there are 116 orphans who all need attention on a regular basis, making it impossible to conduct targeted outreaches on alcohol consumption.

5.5.3 SCHOOLS

The following summary is drawn from interviews with teachers from Maun and Sebina.

Alcohol consumption in schools: Junior secondary school students drink alcohol and are often found at bars and clubs. Especially in Maun, students sometimes spend nights out at bars and clubs that attract drinkers to assemble in car parks after their closure. In response, schools occasionally hold talks with students, utilizing services of the police, S&CD and pastors to discuss issues of behaviour and alcohol abuse. In Tsodilo CJSS, Maun, the school runs a rehabilitation program for students who abuse alcohol. After being identified through teachers or the Guidance and Counselling unit, students are counselled and later taken for rehabilitation camps.

Education and awareness: The Guidance and Counselling curriculum has topics on alcohol and substance abuse, covering definitions, causes, effects, available assistance etc. All students are taken through the modules on alcohol and substance abuse. The national alcohol policy provides for intensified education of students and inclusion of alcohol related material in the curriculum.

5.5.4 NGO'S

The following summary was drawn from interviews with 4 NGOs in Gaborone, Ghanzi and Maun.

Rehabilitation services: Some NGOs such as BOSASNET and WAR provide targeted alcohol related counselling and out-patient rehabilitation. With no in-patient rehabilitation facility in the country, these NGOs can be supported to provide the much needed alcohol and drug abuse specific interventions. Apart from limited coverage and funding challenges NGOs are well placed to drive community based alcohol interventions.

No alternatives: Some NGOs advocate for alternative measures to be put in place to reduce alcohol related harm. For example, the public transport system can improved to reduce the need to drive personal vehicles when people are intoxicated. Organizers of events such as festivals (where alcohol is served), especially in outer areas such as Lion Park, Duma FM grounds can be required to provide alternative transport for patrons to prevent drink-driving after the event.

5.5.5 GOVERNMENT DEPARTMENTS

The following summary was drawn from interviews with government key-informants in all targeted districts.

District wide response: The main concern among government departments was the absence of district focal persons to facilitate and coordinate a multi-stakeholder response and to maintain momentum of the overall anti-alcohol campaign.

Conflict of interest: Sometimes implementers, leaders and government officials (including those in law enforcement) are part of the groups that abuse alcohol. The obvious conflict of interests compromises the amount and quality of effort that these officers can make to respond to harmful alcohol use.

5.5.6 LOCAL AUTHORITIES- DIKGOSI, VDC, RELIGIOUS LEADERS

The following summary was made from interviews with three pastors, two Dikgosi and 11 VDC members.

Social values: A social values perspective needs to be explored in the campaign against alcohol abuse. Alcohol generally compromises a lot of people's values. A social values commission should be established comprising Dikgosi, Pastors, VDC, special groups like women and youth groups to coordinate the efforts of the nation to build proper values and to dialogue on ways to inculcate proper societal values in the population.

Branding of the campaign: The campaign against harmful alcohol use needs to be rebranded to give the message anti-alcohol abuse rather than anti-alcohol. The entry point should not be abstinence but reduction. This will generate wide buy-in and motivate efforts of various players.

6 CONCLUSIONS & RECOMMENDATIONS

6.1 INSTITUTIONAL FRAMEWORK FOR A COORDINATED NATIONAL RESPONSE

Improve the Institutional framework: The institutional framework for the alcohol response needs to be improved on various fronts. Firstly, the Alcohol and Substance Abuse Division needs to be increased significantly from the current six officers to enhance coordination at national level and give the alcohol response a real chance of success. The Human resources upgrade must add a monitoring and evaluation portfolio to the Division to ensure proper management of data and learning. Secondly, fulltime, dedicated alcohol response focal persons need to be appointed at each district to drive a district-wide multi-sectoral response. Stakeholder consultations showed that there are no clear district level structures focusing on alcohol. This compromises sustenance of alcohol efforts and fragments activities that are occasionally done at some districts and the overall national response.

6.1.1 INTER-SECTORAL COLLABORATION

Functional collaboration: It is recommended for Government to strengthen functional and meaningful inter-sectoral and intra-sectoral collaborations to increase the effectiveness of measures taken. For example, there must be a platform for the law enforcement function to provide feedback to the Liquor Licensing committees. Names of establishments that constantly contravene the provisions of their licences (e.g. opening early, closing late, selling liquor to minors and playing excessively high volume music) must be forwarded by the Police to the Liquor Licensing Committees to take appropriate action against them, including suspension, revocation or non-renewal of licence. Liquor licensing processes must also be conducted to give effect to rather than to counteract measures taken to control harmful drinking. Licenses issued to new establishments that are within prohibited proximity to public schools, churches and highways counteracts measures taken to control harmful alcohol consumption.

6.1.2 COORDINATION OF THE RESPONSE:

The Government should consider shifting coordination of the alcohol response from the Ministry of Health to the Office of the President. The Ministry of Health is the main implementer of measures against harmful alcohol use alongside other ministries, civil society organizations and churches. MOH therefore coordinates itself as main implementer as well as parallel ministries and non-state actors. A robust and aggressive response should be coordinated from the highest office to issue clear direction and authority. Coordination of the response from MOH has given some government officials the impression that alcohol is a low priority activity that can be completed when one is sufficiently free or incentivised to do so. This impression is not strange because the HIV/AIDS response, poverty eradication and Disability are all coordinated from Office of the President, indicating the level of priority accorded to them.

6.2 LINKAGES BETWEEN ALCOHOL, HIV/AIDS AND GBV

6.2.1 LINKAGES BETWEEN ALCOHOL AND HIV/AIDS, GBV AND NCDS:

Linkages between alcohol and HIVAIDS, GBV and NCDs do not come out clearly in the policy. In its problem analysis and policy thrusts, the policy needs to strengthen these linkages. A thorough analysis of the alcohol problem and the main health and socio-economic problems associated

with it in the Botswana context will bring HIV/AIDS, NCDs and GBVs to the fore and demonstrate the need for their inclusion in the main action areas. HIV/AIDS, GBV and NCDs are already being addressed in other policies (although there is no specific policy targeting NCDs); so the alcohol policy should incorporate an additional priority action area capturing the linkages between the alcohol response and responses to HIV/AIDS, GBV and NCDs and emphasizing policy coherence.

6.2.2 MAINSTREAM ALCOHOL RESPONSE INTO THE HIV/AIDS, GBV AND NCDS RESPONSES:

Alcohol is a dangerous crosscutting factor that affects a number of health and socio-economic problems, including poverty, unemployment, HIV/AIDS, GBV, NCDS, traffic accidents etc. Whereas it is important to integrate linkages with key issues such as HIV/AIDS, GBV and NCDs into the current alcohol policy, it is more necessary to mainstream alcohol (which is a causal factor) into the responses to all the consequences it is associated with. An effective multi-sectoral response is one that will ensure a sustained campaign against harmful alcohol use across all sectors in government, in private sector and civil society, and infused into the responses against all major priority issues in the country.

6.3 LAW ENFORCEMENT

6.3.1 IMPROVE LAW ENFORCEMENT:

Enforcement of available laws that limit availability and consumption of alcohol to specific areas need to be improved across the country. In all districts, stakeholders lamented the weak implementation of alcohol related laws. Emphasis must be placed on ensuring liquor outlets' compliance with the set opening and closing hours; preventing free, undisturbed consumption of alcohol in the streets; preventing consumption of alcohol while driving; preventing sale of alcohol to minors. A deliberate financial and infrastructural investment needs to be made by the Government to increase the presence of Police officers on the ground and to avail necessary resources (such as vehicles) to improve law enforcement. If Government does not invest in controlling harmful alcohol consumption, the same amount of investment or even more funds will still be committed to addressing alcohol related crimes and other harmful consequences of excessive drinking.

6.3.2 ENACT STIFFER REGULATIONS:

Looking at the centrality of alcohol in causing disease, accelerating new HIV infections, influencing gender based violence and aggressive behaviour, causing other penal code crimes such as murder, rape and defilement, the government needs to enact a law prohibiting intoxication in public. The law will criminalize intoxication in public and so help to reduce or curb public acceptance of intoxication. Currently, drinkers can be intoxicated in public and even be disorderly without incurring any criminal liability. Children grow up seeing intoxicated people in public and this normalizes the behaviour and helps to build a culture of public drinking and intoxication.

Several countries and states within countries have public intoxication laws to limit public nuisance and to reduce harm to third persons resulting from excessive drinking. In Victoria, Australia being "drunk in a public place" and being "drunk and disorderly in a public place" are distinct offences contained in the Summary Offences Act 1966 (Victoria state, 1966). Sections 12-18 of the Licensing Act, 1872 prohibits drunkenness in public places as well as drunk and disorderly behaviour in public places in the United Kingdom, except Scotland (The United Kingdom, 1872). In the US public intoxication is outlawed in several states, where it is considered to be a form of misdemeanour

- Botswana can follow these states and enact a public intoxication law to deter citizens from drinking to intoxication.

Blood Alcohol Concentration (BAC) is already being regulated for motorists in order to protect the public from alcohol related road traffic crashes. However, no legal protection exists in relation to disorderly behaviours, use of obscene language in public associated with intoxication. The government must move towards stiffer regulations to protect the public from alcohol related harm apart from road traffic crashes, and to protect itself and its tax payers from extra-ordinary public health expenditure raised by excessive alcohol consumption.

6.4 TRADITIONAL BREWS

6.4.1 TRADITIONAL BEER:

Standard recipes for legal traditional brews must be developed and alcohol content determined through quality standards and legal frameworks. Currently traditional beers are only identified by their dominant ingredients such as morula for nkumbi beer, sorghum for mokuru, and wild berries for khadi and water melon for setopoti. How much of the main ingredients and what other ingredients can be added remains unspecified in statute and open to any brewer's choice. Stakeholders in Ghanzi revealed that conventional traditional beer recipes are often adulterated by adding special ingredients that enhance the potency of the beer without changing its appearance. The open-endedness of the composition of traditional beers leaves too much freedom to brew illicit substances without clearly contravening the law. The Government must engage the National Food Technology Research Centre (NAFTEC) and other research institutions to determine the alcohol content of legal traditional beers and recommend standard or guiding recipes for brewers to maintain legal alcohol content.

6.5 RESEARCH AND KNOWLEDGE SHARING

Increased production and dissemination of knowledge: There is limited literature on alcohol consumption in Botswana. Comprehensive studies on consumption levels, patterns, details of associated harm, socio-economic determinants of harmful behaviour related to alcohol are very limited. A few materials that exist locally are generally from short-term consultancies. There is therefore need to carry out more studies on alcohol consumption in Botswana.

Information dissemination also needs to be strengthened, including dissemination of the National Alcohol Policy. The policy document, a break-down of its priority areas, key strategies, available evidence on alcohol consumption need to be packaged and shared with relevant government departments, private sector entities, civil society organizations, tribal authorities, churches to enable them to participate meaningfully in the multi-sectoral response

6.6 INCLUSIVENESS OF THE RESPONSE

6.6.1 INCREASED AWARENESS:

The national alcohol response needs to be re-branded to ensure wider public buy-in and more community involvement. The public generally does not seem to understand the complexity and magnitude of the alcohol problem in the country. Apart from a simple acknowledgement that alcohol is widely consumed, most people do not seem to understand how alcohol affects rates of HIV infections, numerous non-communicable diseases, violence and aggressive behaviour, family breakdowns, poverty, poor school performance, low productivity, road traffic crashes, disability, mortality or high public expenditures on health, law enforcement and public education

etc. Measures that have been put in place to control alcohol consumption have therefore been associated with preferences of the current government rather than the actual problem. This misconception has not helped the alcohol response. A case for a robust, aggressive and unapologetic response to alcohol abuse in the country needs to be made through intense public education and dialogue with citizens. The problem is real and must be shown as such to the public. Stakeholder consultations revealed that public opinion about measures taken to limit the alcohol consumption is generally negative. Measures are too often regarded an unmerited initiatives of the Office of the President based more on preference than necessity. Looking at the magnitude of the alcohol problem in the country, this view is dangerous and needs to be changed urgently through deliberate rebranding of the response.

7 LIST OF REFERENCES

AVERT (2015) HIV and AIDS in Botswana. [Online] http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/botswana [Accessed 18 Sept 2016].

African Health Observatory (2016). Analytical summary - Non-communicable diseases and conditions [Online] http://www.aho.afro.who.int/profiles_information/index.php/Botswana:Analytical_summary_-_Non-communicable_diseases_and_conditions [Accessed 26 Nov 2016].

Babor, T. (2010). Alcohol: No Ordinary Commodity- A Summary of the Second Edition. Addiction, 105, 769-779.

Bakke, O and Endal, D. (2009). Vested Interests in Addiction Research and Policy Alcohol Policies out of Context: Drinks Industry Supplanting Government Role in Alcohol Policies in Sub-Saharan Africa. Addition. 105, pp22-28

Bakke, O and Endal, D. (2014). Prevention Works: A tool for addressing alcohol and drug problems in a development context.

Brekke, T and Sketting, A. (2012) Coherence of Norwegian policy for alcohol, narcotic drugs and tobacco. In Muscat, R. and Pike, B. (eds) (2012). Reflections on the concept of coherency for a policy on psychoactive substances and beyond. Strasbourg, Council of Europe Publishing.

Center for Disease Control (2013). Binge Drinking: A Serious, Under-Recognized Problem among Women and Girls. [Online] http://www.cdc.gov/vitalsigns/bingedrinkingfemale/ [Accessed 14 Sept 2016].

Collin, J. and Casswell, S. (2016). Alcohol and the Sustainable Development Goals. The Lancet [online] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30827-3 [Accessed 20 Sept 2016]

Davis, R., et. al. (2014). Theories of Behavior and Behaviours Change Across the Social and Behavioral Sciences: A Scoping Review. Health Psychology Review, 9(3), 323-344).

Finlay, J. and Jones, R.K (1982). Alcohol Consumption and the nature of Alcohol related problems in Botswana: A Preliminary report. African e-Journals Project. [Online] http://digital.lib.msu.edu/projects/africanjournals/ [Accessed 20 Sept 2016]

Foundation for a Drug Free World (2016). What is Binge Drinking? Online, http://www.drugfreeworld.org/drugfacts/alcohol/what-is-binge-drinking.html, Retrieved 16 Nov 2016.

Gender Links (2012). Botswana Gender Based Violence Indicators Study. Gender Links and Women Affairs Department, Botswana, Gaborone.

Gender Links (2015). SADC Gender Protocol Barometer 2015: Botswana. Gender Links

Gender Links (2015). Voices from Botswana: Gender Based Violence Survivors Speak. “I” Stories. Gender Links.

Government of Botswana (2009).The Second Botswana National Strategic Framework for HIV and AIDS 2010 – 2016.Gaborone, National AIDS Coordinating Agency, Ministry of State President.

Government of Lesotho (2015). Global AIDS Response Progress Report 2015: Follow-Up to the 2011 Political Declaration on HIV/AIDS: Intensifying Efforts to Eliminate HIV/AIDS. Maseru, Ministry of Health.

Green Facts: Facts on Health and the Environment (2016). Alcohol. [Online] http://www.greenfacts.org/en/alcohol/l-2/05-social-economic-problems.htm [Accessed 20 Sept 2016]

Index Mundi (2016). Cause of death, by non-communicable diseases (% of total). [Online] http://www.indexmundi.com/facts/indicators/SH.DTH.NCOM.ZS/compare?country=bw [Accessed 20 Sept 2016]

Kagisano Society Women's Shelter (2016). Mid-Term Evaluation: "Reaching Out To Communities to Strengthen Their Response to GBV, Harmful Practices and HIV and AIDS" Project. Unpublished.

Majelantle R. G, Bainame, K., Masupu K, and Nkawana P. (2011). Botswana Youth Risk Behavioural Surveillance Survey. Gaborone, Ministry of Health.

Ministry of Health (2016). Departments and Programs. [Online], http://www.moh.gov.bw/about_us_departments.html. [Accessed 6 December 2016]

Ministry of Health (2016). National AIDS Coordinating Agency (NACA). [Online], http://www.gov.bw/en/Ministries--Authorities/Ministries/State-President/National-AIDS-Coordinating-Agency-NACA1/About-NACA1/Background/ [Accessed 6 December 2016]

Mirkovic, A (2011). Alcohol Policies and Their Perceived Effectiveness in Botswana Alcohol Policies and their Perceived Effectiveness in Botswana. [Online] www.acm.edu>anja_mirkovic_poster [Accessed 14 Sept 2016]

Muscat, R. and Pike, B. (2012). Reflections on the concept of coherency for a policy on psychoactive substances and beyond. Strasbourg, Council of Europe Publishing.

Muscat, R., van de Mheen, D. and Barendregt, C (2010). Towards an Integrated Policy on Psychoactive Substances: A Theoretical and Empirical Analysis. Council of Europe

Naik, N.T.K. and Lal, S (2013) Impact of Alcohol Consumption on Health and Economy (A Focus on Mc Dowellization of World). IOSR Journal of Nursing and Health Science (IOSR-JNHS) 1(5) PP 18-23.

National Institute on Alcohol Abuse and Alcoholism (NIAA) (2015). Alcohol's Effects on the Body. [Online] https://www.niaaa.nih.gov/alcohol-health/alcohols-effects-body [Accessed 20 Sept 2016]

Obot I (2014). Case Study on Effective Interventions for Reducing Harmful Use of Alcohol in Botswana. Unpublished.

Phorano O. D., Nthomang K., & Ntseane, D. (2005). Alcohol abuse, gender-based violence and HIV/AIDS in Botswana: establishing the link based on empirical evidence. Journal of Social Aspects of HIV/AIDS, 4(5), 188-202

Pitso, J.M.N. & Obot, I.S. (2011). Botswana Alcohol Policy and the Presidential Levy Controversy. Addiction, 106, 898-905

Rehm J, et al. (2003). The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease – An overview. Addiction. 98:1209–1228. [Online] http://onlinelibrary.wiley.com/doi/10.1046/j.1360-0443.2003.00467.x/abstract [Accessed 14 Sept 2016]

Republic of Botswana (2004). Liquor Act, 2003. Act No. 9 of 2004. Gaborone: Government Printer.

Republic Of Botswana (2005). Botswana AIDS Impact Survey II: Popular Report. Gaborone, Central Statistics Office.

Republic Of Botswana (2008). Botswana AIDS Impact Survey III. Gaborone, Central Statistics Office.

Republic of Botswana (2008). Levy on alcohol beverages fund order, 2008. Gaborone: Botswana Government Printer.
Republic of Botswana (2008). Liquor Regulations, 2008. Statutory Instrument No. 26 of 2008. Gaborone: Government Printer.

Republic of Botswana (2010). Botswana STEPS survey: Chronic Disease Risk Factor Surveillance Gaborone: Ministry of Health, DPH, Disease Control Division.

Republic of Botswana (2010). National Alcohol Policy for Botswana. Gaborone, Ministry of Trade and Industry.

Republic of Botswana (2012) Botswana National Policy on HIV and AIDS. Gaborone, Ministry of Health.

Republic of Botswana (2012). Evaluation of the Alcohol Levy in Botswana. Gaborone, Ministry of Health

Republic Of Botswana (2013). Botswana AIDS Impact Survey IV: Popular Report: Central Statistics Office.

Republic of Botswana (2014). Botswana 2013 Global AIDS Response Report. Gaborone, National AIDS Coordinating Agency.

Republic of Botswana (2016) Botswana National Policy on Gender and Development. Gaborone, Ministry of Labour and Home Affairs.
Republic of Botswana (2016). Women Affairs. [Online] http://www.gov.bw/Global/Women%5B1%5D.pdf [Accessed 21 Sept 2016]

Republic of South Africa (2016). Central Drug Authority Ready to Implement National Drug Master Plan. [Online] http://www.dsd.gov.za/cda/index.php?option=com_content&task=view&id=71&Itemid=119 [Accessed 12 October 2016].

Rossow I, Bogstrand ST, Ekeberg O and Normann PT (2013). Associations between heavy episodic drinking and alcohol related injuries: a case control study. BMC Public Health. [Online] http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1076 [Accessed 20 Sept 2016]

Samarasinghe, D. (2006). Strategies to Address Alcohol Problems. Neaimala-Dehiwala, FORUT.

Sebonego, P. (2015). Alcohol Interventions on Drug Abuse: Botswana's New Epidemic. Presentation at Botswana Drug Abuse High Level Pitso- 2015. Unpublished.

Selemogwe, Mphele and Manyanda (2014). Drug Use Patterns and Socio-Demographic Profiles of Substance Users: Findings From a Substance Abuse Treatment Programme in Gaborone, Botswana. African Journal of Drug & Alcohol Studies, 13(1).

Sinkamba, R (2015). Alcohol abuse and interventions strategies in Botswana and China: A preliminary study. PULA: Botswana Journal of African Studies 29(1)

Soul City Institute (2008). Multiple and Concurrent Sexual Partnerships in Southern Africa: A Ten Country Research. Soul City

Statistics Botswana (2013). Botswana Chronic diseases. [Online] http://botswana.opendataforafrica.org/qzennz/botswana-chronic-diseases [Accessed 21 Sept 2016]

The United Kingdom (1872) The Licensing Act, 1872. Online, http://www.legislation.gov.uk/ukpga/1872/94/pdfs/ukpga_18720094_en.pdf?timeline=true&view=extent. Retrieved 9 Nov 2016.

U.S. Department of Health and Human Services (2015). Alcohol: A Women's Health Issue. National Institutes of Health National Institute on Alcohol Abuse and Alcoholism NIH Publication. Rockville, National Institute on Alcohol Abuse and Alcoholism

United Nations (2016). Transforming our World: The 2030 Agenda for Sustainable Development. New York, United Nations

United Nations Development Group (2016). The Sustainable Development Goals are coming to Life: Stories of Country Implementation and UN Support. New York. United Nations

WHO (2014). Non-communicable Diseases (NCD) Country Profiles: Botswana. [Online] http://www.who.int/nmh/countries/bwa_en.pdf [Accessed 21 Sept 2016].

Wiesar et. al (2006). A population-based study on alcohol and high-risk sexual behaviours in Botswana. PLoS Medicine, 3(10).

World Health Organization (2004). Neuroscience of Psychoactive Substance Use and Dependence. Geneva. WHO

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

World Health Organization (2013). Global and Regional Estimates of Violence against Women: Prevalence and Health effects of Intimate Partner Violence and Non-partner Sexual Violence. Geneva. WHO, Department of Reproductive Health and Research

World Health Organization (2013). The World Health Report 2013. Geneva. WHO

World Health Organization (2014). Global Status Report on Alcohol and Health. Geneva. WHO

8 ANNEXURE

ANNEX 1: LIST OF INTERVIEWS

Key-informant	Sex	Office/ Title	District	Contacts
Gomolemo Resesigo	F	Country Manager, Gender Links	Gaborone	771510179; botsmanager@gendrelinks.org.za
Violet Losike	F	District AIDS Coordinator	Gaborone	77603034; vlosike@gov.bw
Phenyo Sebonego	M	Chief Health Officer (Head of Division), Alcohol and Substance Abuse Division	Gaborone	71308419; psebonego@gov.bw
Lorato Koosaletse	F	Acting Clinical Programme Manager, BOSASNET	Gaborone	3959119
Wazha Dambe	M	Substance Abuse Counsellor, BOSASNET	Gaborone	3959119
Isaac Tokonyane	M	Substance Abuse Counsellor, BOSASNET	Gaborone	3959119
Pastor Simane	M	Secretary General, Botswana Council of Churches	Gaborone	3951981
Pastor Godfrey Jankie	M	Programme Manager, Botswana Council of Churches		3951981
Lawrence Mogae Mhaladi	M	Kgosi		5920817/ 71692769
Oreletse R. Gareekepele	M	District Administration officer	Molepolole	5910589/72577738
Theresa N. Makati	F	District AIDS Coordinator	Molepolole	5910579/71525416
Kemiso Ntshetse		M&E Officer, DAC Office	Molepolole	5910579
Merapelo Sengalo		Social worker	Molepolole	540 4183
Boago Lebang	F	District AIDS Coordinator	Goodhope	540 4309
G. Nkwe Tabane	M	Deputy District Commissioner	Goodhope	540 4159
Barola Marumola Jnr	F	Kgosi	Goodhope	540 4183
Tshoganetso Mahupe	M	District AIDS Coordinator	Goodhope	659 6356

Tshepang Thomane	F	Health Education Officer (DHMT)	Ghanzi	659 6356
Kabo Stoffel	F	Field officer, Kagisano Society Women's shelter	Ghanzi	659 6356
Keatlametse Kabelo	F	Pastor, Bible Life Ministries	Ghanzi	71 516 322
Bakani Mathumo	M	District Administration officer	Ghanzi	686 0269
Onkokame Badubi	M	Peer Educator: Tsodilo JSS	Maun	686 0549
Mr Lefile Thipe	M	(Guidance& Counseling office)	Maun	6862136
Kethuse Puso	M	Senior District youth officer MYSC	Maun	686 5617
Ivy Kgangmotse	M	Senior Gender Officer, Gender Affairs Department	Maun	ikgangmotse@gmail.com
Chaunoda Moroka	F	Substance Abuse Counselor, Women Against Rape	Maun	War.counsellorc@gmail.com
Phillimon Ishmael	F	Substance Abuse Counselor, Women Against Rape	Maun	74 298 992
Phuthego Letso	M	VDC Chairperson	Sebina	
Phuthego Botho	F	VDC Treasurer	Sebina	
Motswaledi Onalenna	F	Additional member, Sebina VDC	Sebina	
Mbayani Phalalo	F	VDC Secretary	Sebina	
Violet Thebatsela	M	Additional member, Sebina VDC	Sebina	71 759 614
Nkimisang Thamae	F	Social Worker	Sebina	298 1226
Cement Gareutwane	M	Head of Department, Shangano JSS	Sebina	
Albert Kobedi	M	TIDIMA VDC Chairperson	Mahalapye	
	M	Additional member, TIDIMA VDC	Mahalapye	
Mogomotsi Ramatswidi	F	Additional member, TIDIMA VDC	Mahalapye	
Superintendent K. Kwena	M	Botswana Police Service	Mahalapye	471 1293

ANNEX 2: DATA COLLECTION INSTRUMENTS

INTERVIEW GUIDE

INTRODUCTION OF MODERATOR

Hello, my name is Lawrence Kubanga, a consultant working with UNDP and Ministry of Health to do a desk review of the national alcohol policy, particularly assessing the extent to which the policy addresses HIV/AIDS, Non-Communicable Diseases (NCDs) and Gender Based Violence (GBV). You have been selected to give your views in your capacity as _____; we believe that your opinions and experiences will make valuable contribution to this exercise that we are undertaking. Thank you for accepting to do this interview. I am mindful of the fact that you have a lot to do and will do everything to make this as brief and as painless as possible.

CONFIDENTIALITY

This interview is quasi-anonymous and confidential, which means that although we will not link your responses to you as an individual, we may quote that the response is by a _____ e.g DAC, Police Officer.

FORMAT OF THE DISCUSSION

I will ask the questions and please answer as extensively as you can. I will audio-record responses to remind myself at a later stage what we discussed here. Do you have any questions before we start?

IDENTIFICATION INFORMATION

Date and Venue	
Interviewer	
Interviewee name	
Sex	
Rank	
Village/Town	

QUESTIONS FOR GOVERNMENT OFFICIALS

1. Is excessive drinking is a problem in your district? Why or why not? Which one poses the most challenges, beer, wine and spirits or traditional brews?
2. Who is doing what to address alcohol abuse in your district? Is there a district plan that addresses alcohol abuse? What is the role of your office? Are you playing your role effectively? What can be done to enhance your efforts?
3. How is the district or local response linked to the national response? Do you report your

efforts against alcohol abuse to your headquarters? What are the reporting channels?

4. The alcohol policy prioritizes inter-sectoral collaboration and community action. Can you say that all relevant stakeholders take part in the alcohol response? Who is not involved that should participate?
5. Do you think the public is fully aware of the nature of the alcohol problem in your district? Who is leading public education and awareness in your district? What is the public opinion regarding measures that have been taken to control alcohol related harm? (such limits on time and places to trade alcohol, minimum age to purchase and/or drink alcohol, increased prices)
6. Do you think available legal measures are sufficient to address the problem of alcohol? Where are the gaps?
7. Do you think there are associations between alcohol consumption and HIV/AIDS? Please explain.
8. Are there any associations between alcohol consumption and non-communicable diseases such as cancers, liver diseases, heart diseases, diabetes, etc? Please explain. What do you think can be done to address these given this association?
9. Do you think there are associations between alcohol consumption and gender based violence? Please explain. What do you think can be done to address this given this association?
10. Have you ever seen, read or heard about the national alcohol policy?
11. Do you think the alcohol policy should address issues related to HIV/AIDS, NCDs and GBV? Why or why not?
12. Do you think the current alcohol policy adequately addresses issues of HIV/AIDS, NCDs and GBV? Where are the gaps, if any?
13. What do you think should be done to integrate the HIV/AIDS, NCDs and GBV into the alcohol policy?
14. Do you think the national alcohol response is effective to reduce excessive drinking and its associated negative consequences? If yes, explain. If no, what are the main barriers? And what else can be done?

QUESTIONS FOR CIVIL SOCIETY ORGANIZATIONS

1. Is excessive drinking is a problem in your district? Why or why not? Which one poses the most challenges, beer, wine and spirits or traditional brews?
2. Does your organization implement any projects related to prevention of alcohol abuse? If yes, what project, where, targeting who?
3. Who else is doing what to address alcohol abuse in your district? Is there a district plan that addresses alcohol abuse? If, yes, is it linked to the national alcohol response?
4. What is the public opinion about alcohol abuse in the country? Do you think people see it as a problem? What about the efforts being made to address alcohol, are they popular? Do you think the public opinion is one that is pro-efforts being made or against? Why?
5. Do you think there are associations between alcohol consumption and HIV/AIDS? Please explain.
6. Are there any associations between alcohol consumption and non-communicable diseases such as cancers, liver diseases, heart diseases etc? Please explain
7. Do you think there are associations between alcohol consumption and gender based violence? Please explain.

8. Have you ever seen, read or heard about the national alcohol policy?
9. Do you think the alcohol policy should address issues related to HIV/AIDS, NCDs and GBV? Why or why not?
10. Do you think the current alcohol policy adequately addresses issues of HIV/AIDS, NCDs and GBV? Where are the gaps, if any?
11. What do you think should be done to integrate the HIV/AIDS, NCDs and GBV into the alcohol policy?
12. Do you think the national alcohol response is effective to reduce excessive drinking and its associated negative consequences? If yes, explain. If no, what are the main barriers? And what else can be done?

QUESTIONS FOR TRIBAL AND RELIGIOUS LEADERS

1. Do you think excessive drinking is a problem in your community? Why or why not? Who is mostly affected? Why?
2. Do you think your community understands the seriousness of the alcohol problem? Please explain.
3. Are you or anyone in your community doing anything to address the situation? If yes, who is doing what? If no, why not?
4. What are the main problems facing your community? Are they associated with alcohol consumption in any way? If yes, how?
5. Do you think there are associations between alcohol consumption and HIV/AIDS? Please explain.
6. Are there any associations between alcohol consumption and non-communicable diseases such as cancers, liver diseases, heart diseases etc? Please explain
7. Do you think there are associations between alcohol consumption and gender based violence? Please explain.
8. Have you ever seen, read or heard about the national alcohol policy?
9. Do you think the alcohol policy should address issues related to HIV/AIDS, NCDs and GBV? Why or why not?
10. Do you think the current alcohol policy adequately addresses issues of HIV/AIDS, NCDs and GBV? Where are the gaps, if any?
11. What do you think should be done to integrate the HIV/AIDS, NCDs and GBV into the alcohol policy or the alcohol response?
12. Do you think the national alcohol response is effective to reduce excessive drinking and its associated negative consequences? If yes, explain. If no, what are the main barriers? And what else can be done?
13. What do you consider to be your role in the fight against alcohol abuse in your community or in your country? Are you playing your role effectively? In no, why not? And what can be done to enhance your efforts?
14. Dikgosi have delegated authority to enforce Traditional Beer Regulations of 2011. Have you ever seen them or been taught about them? How is this different from your usual application of the law among your people? Is it easy for you to apply these regulations and enforce the law? Where are the issues?

ANNEX 3: DESCRIPTION OF THE DESK REVIEW TEAM

Lawrence Kubanga	MA- Development Studies; LLB; BA- English; Diploma- Teaching and Training. He is a public health and socio-economic development professional and Monitoring and Evaluation expert with extensive experience leading research and program evaluations in Botswana, South Africa, Zambia, Mozambique, Malawi, Namibia, Swaziland, Tanzania and Lesotho.
Phenyo Sebonego	Chief Health Officer, Alcohol and Substance Abuse Division, Department of Public Health, Ministry of Health, Botswana. He heads the Division and oversees Botswana's Alcohol Campaign.
Mavis Bengtsson	Program Specialist- Health, HIV/AIDS, Gender and Human Rights for the United Nations Development Programme, Botswana Office
Moagi Gaborone	Health Information and Promotion Officer, world Health Organization, Gaborone, Botswana
Dag Rekve	Technical Officer, Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland.