

REGIONAL COMMITTEE FOR AFRICA**ORIGINAL: ENGLISH**Seventy-third sessionGaborone, Republic of Botswana, 28 August–1 September 2023Provisional agenda item 12**FRAMEWORK FOR IMPLEMENTING THE GLOBAL ALCOHOL ACTION PLAN,
2022–2030 IN THE WHO AFRICAN REGION****Report of the Secretariat****EXECUTIVE SUMMARY**

1. Alcohol is a toxic and psychoactive substance with dependence-producing properties. The “harmful use of alcohol” is defined as “drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as patterns of drinking that are associated with increased risk of adverse health outcomes”. Harmful use of alcohol is a causal factor in more than 200 diseases and injuries.

2. In 2010, the Regional Committee endorsed “Reduction of the harmful use of alcohol: A strategy for the WHO African Region”. The 2010 Strategy aimed “to contribute to the prevention or at least reduction of harmful use of alcohol and related problems in the African Region”. Progress has been made, with up to 15 countries either revising their alcohol policies or developing them. Alcohol per capita consumption has reduced.

3. A number of issues and challenges hampered the implementation of the 2010 African Region alcohol strategy, including lack of multisectoral coordination, with only nine countries having an entity for that purpose; limited legislation and poor enforcement of laws and regulations; weak health care systems; alcohol industry interference as reflected in unrestricted advertising, sponsorship of sporting and youth activities, and intrusion in the process of policy development. Drug use is a growing problem in the Region, and linked to alcohol use.

4. This Framework builds on the previous Regional strategy, while drawing from the Global alcohol action plan to strengthen the implementation of the strategy to reduce the harmful use of alcohol (WHA75(11), 2022). The goal of this Framework is to significantly reduce morbidity and mortality due to alcohol consumption in the African Region. Its objectives are to: (i) increase implementation and enforcement of high-impact policy options and interventions to reduce the harmful use of alcohol in the African Region; (ii) strengthen multisectoral actions through effective governance, enhanced political commitment, leadership, dialogue, and coordination; (iii) enhance the capacity of health and social care systems to prevent and treat disorders due to alcohol use as an integral part of universal health coverage (UHC) and in alignment with the 2030 Agenda for Sustainable Development and its health targets; (iv) raise awareness of the risks and harms associated with alcohol consumption and its impact on the health and well-being of individuals, families, communities and nations; (v) strengthen information systems and research for monitoring alcohol consumption, alcohol-related harm, their determinants and modifying factors, and policy responses at all levels; and (vi) increase the mobilization of resources required for appropriate and sustained actions

to reduce the harmful use of alcohol at all levels. The guiding principles include adopting an approach based on evidence, human rights, equity, multisectoral action and the life course, empowering people and communities, and ensuring protection from commercial interests.

5. Priority interventions and actions include the establishment of multisectoral coordination mechanisms to oversee the implementation of the alcohol policy; development of multisectoral alcohol harm reduction policies, accompanied by development and/or review of legislation. Policy measures include reducing the affordability, acceptability, and availability of alcohol, strengthening the health sector to deal with alcohol use disorders, and establishing drink-driving countermeasures. A recommendation is made to develop a Strategy to combat the related escalating use of drugs and other addictive behaviours in the WHO African Region.

6. The Regional Committee is invited to consider and adopt the actions proposed.



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INTRODUCTION

1. Alcohol is a toxic and psychoactive substance with dependence-producing properties. In many societies, alcoholic beverages are a routine part of the social landscape. The “harmful use of alcohol” is defined as “drinking that causes detrimental health and social consequences for the consumer, the people around him/her and society at large.”¹ Harmful use of alcohol accounts for 5.1% of all deaths in the African Region.² In the African Region, drug use and drug use disorders are on the increase³

2. In 2010, the Regional Committee endorsed “Reduction of the harmful use of alcohol: A strategy for the WHO African Region,” which aimed “to contribute to the prevention or at least reduction of harmful use of alcohol and related problems in the African Region”⁴. Progress has been made since 2010, with seven Member States revising their outdated alcohol policies⁵ and seven others that did not have such policies developing them⁶. However, alcohol per capita consumption did not change between 2005 and 2016, remaining at 6.3 litres. The adult per capita consumption of alcohol in the general population decreased by 24% from 6.3 litres in 2016 to 4.8 litres in 2019.⁸

3. Considering the slow pace of implementation of the WHO Strategy to reduce the harmful use of alcohol, the 146th Executive Board adopted a decision on accelerating action to reduce the harmful use of alcohol. Acting on that decision, the Seventy-fifth World Health Assembly adopted the Global alcohol action plan 2022–2030 to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and accelerate work towards achieving the Sustainable Development Goals (SDGs).

4. This Regional Framework updates the existing regional strategy, which is 13 years old. The Regional Framework also operationalizes the new action points in the Global alcohol action plan and addresses the challenges encountered in the implementation of alcohol harm reduction activities in the Region. The Framework also takes into account The World Drug Report 2023 and the rapid rise of drug use and drug use disorders in the Region

CURRENT SITUATION

5. The 2019 estimate of alcohol per capita consumption in the world, measured in litres of pure alcohol per person 15 years of age or older, was 5.8, a 5% relative decrease from 6.1 in 2010.⁹ At the global level, alcohol is a causal factor for over 200 diseases and injuries including cancers, cardiovascular diseases, suicide, liver diseases, road injuries and violence, and communicable diseases like tuberculosis and HIV/AIDS.¹⁰ Globally, between 2011 and 2021, there has been a 45% increase in drug use disorders¹¹

6. The African Region has a high level of lifetime abstainers (57.5%).¹² However, persons who drink alcohol consume high volumes, with detrimental effects for themselves and the society.

¹ WHO (2022) Global Alcohol Action Plan 2022-2030 (https://apps.who.int/gb/ebwha/pdf_files/EB150/B150_7Add1-en.pdf, accessed 10 December 2022)

² WHO (2018) Alcohol and Health

³ UNODC (2023) World Drug Report ([World Drug Report 2023 \(unodc.org\)](https://www.unodc.org/wdr2023/) accessed 03 July 2023)

⁴ WHO African Region (2010) Reduction of the harmful use of alcohol: a strategy for the WHO African Region

⁵ Algeria, Benin, Cabo Verde, Central African Republic, Madagascar, Seychelles and South Africa

⁶ Angola, Botswana, Ghana, Kenya, Malawi, Nigeria, and Uganda

⁷ World Health Organization. Global Information System on Alcohol and Health (GISAH)

⁸ WHO (2018) Global Status Report on Alcohol and Health

⁹ WHO (2018) Global Status Report on Alcohol and Health

¹⁰ WHO (2018) Global Status Report on Alcohol and Health

¹¹ UNODC (2023) World Drug Report ([World Drug Report 2023 \(unodc.org\)](https://www.unodc.org/wdr2023/) accessed 03 July 2023)

¹² WHO (2018) Global Status Report on Alcohol and Health

While total alcohol per capita consumption (APC) in the African Region has decreased, alcohol consumption among drinkers increased from 17.2 L in 2010 to 18.4 L in 2016.¹³ In Africa, the primary drugs consumed are opioids (37%) and cannabis (36%). Cannabis is the main drug of concern for people on treatment and use is highest in West and Central Africa. Cannabis is used in about 7% of the population, up to 10% in West and Central Africa¹⁴.

7. Of particular concern are the number of young people aged 15 to 19 years who consume alcohol, estimated at 21.4% in 2016,¹⁵ and those with patterns of heavy episodic drinking (HED). Recent estimates (2018) of the prevalence of HED in people aged 15 years and above stand at 17.4% for the general population and 50.2% among drinkers.¹⁶ For young persons aged 15 to 19 years, the figure is 12.7% for all and 55.1% among drinkers.¹⁷ This is worrying as Africa is home to the youngest population globally,¹⁸ and children should not be consuming alcohol.

8. In 2016, the aged-standardized alcohol-attributable burden of disease and injury was highest in the WHO African Region with 70.6 deaths per 100 000 people. This is due to the large burden of attributable disease caused by tuberculosis, cardiovascular diseases, digestive diseases and injuries.¹⁹ It is estimated that 10% of women of reproductive age – 15 to 49 years – in the African Region drink alcohol and 3% are heavy episodic drinkers. The prevalence of foetal alcohol syndrome in the African Region is 14.8 per 10 000 population.²⁰

9. In relation to restricting availability, 5 out of 47 Member States have legislation or regulations that limit off-premises purchase of alcohol.²¹ Another 37 Member States have laws or regulations that limit the age for on-premises service.²² However, these laws and regulations are not uniformly enforced. As a result of the COVID-19 pandemic, online sale and home delivery of alcohol made access much easier.

10. Drink driving countermeasures are an effective strategy to reduce the harmful use of alcohol. The gold standard for blood alcohol concentration (BAC) limits is between 0.02% and 0.05%. In the African Region, only 25 of the 47 Member States carry out random blood alcohol testing.²³ While 35 Member States have specified the legal blood alcohol concentration limit,²⁴ only 12 have set it at 0.05% or below.²⁵

¹³ WHO (2018) Global Status Report on Alcohol and Health

¹⁴ UNODC (2023) World Drug Report ([World Drug Report 2023 \(unodc.org\)](https://www.unodc.org/wdr2023/) accessed 03 July 2023)

¹⁵ WHO (2018) Global Status Report on Alcohol and Health p.50

¹⁶ WHO (2018) Global Status Report on Alcohol and Health p. 49

¹⁷ WHO (2018) Global Status Report on Alcohol and Health p. 53

¹⁸ (<https://www.theworldcounts.com/populations/continents/africa>, accessed 11 December 2022)

¹⁹ WHO (2018) Alcohol and Health p. 65

²⁰ Popova s et al (2019) Epidemiology of Fetal Alcohol Spectrum disorders .

(https://www3.paho.org/hq/index.php?option=com_docman&view=download&slug=epidemiology-of-fetal-alcohol-spectrum-disorder-svetlana-popova&Itemid=270&lang=es, accessed 11 December 2022)

²¹ Angola, Algeria, Botswana, Burundi, Cabo Verde, Cameroon, Chad, Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

²² Angola, Algeria, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Chad, Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Rwanda, Senegal, Seychelles, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia Zimbabwe

²³ Angola, Benin, Botswana, Cabo Verde, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Seychelles, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

²⁴ Angola, Algeria, Benin, Botswana, Burkina Faso, Cabo Verde, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Equatorial Guinea, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Seychelles, South Africa, Uganda, United Republic of Tanzania, Zambia Zimbabwe

²⁵ Algeria, Benin, Botswana, Burkina Faso, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Eswatini, Madagascar, Mali, Mauritius, South Africa.

11. The African Region has a **shortage of treatment units for alcohol and drug use disorders** (AUDs) with very limited rehabilitation services in the public sector, while private facilities are not regulated and only available to the higher income population. Health care workers, especially those in emergency rooms, have not been trained to carry out screening, brief interventions and referral for treatment.

ISSUES AND CHALLENGES

12. **Lack of policies on drug and alcohol control and lack of intersectoral coordination:** **Only nine Member States out of 47 have a central coordinating entity** to oversee alcohol policy implementation.²⁶ **As many as 29 Member States²⁷ in the Region do not have alcohol policies**, while Côte d'Ivoire and Niger have alcohol policies dating back to 1964 and 1983 respectively. Drug control policies are separate from alcohol policies.

13. **Limited and very weak regulation on where and to whom alcohol can be sold:** Alcohol can be very easily bought in supermarkets, neighborhood shops and petrol stations. Children are not prohibited from purchasing alcohol, neither are there checks on the age of persons consuming alcohol. Five Member States have regulations that allow children below the age of 18 years to be served alcohol on premises.²⁸ Only 28 Member States have laws or regulations that prevent illegal sale of alcohol.²⁹

14. **Weak health care systems in general:** The state of the health systems in the African Region equally impacts services for alcohol and drug use disorders. The treatment available in the public service is limited to management of acute withdrawal, often as an emergency admission. Once the acute phase is over, there are few public rehabilitation services. This results in revolving door admissions for acute care, which is not effective for long-term remission and costly for the health system.

15. **High cost of private rehabilitation:** Public rehabilitation services are not widely available in the Member States. Private rehabilitation is not widely available and is very expensive, ranging from US\$ 1000 to US\$ 15 000 per month, and the duration of rehabilitation ranges from three to six months. The majority of private rehabilitation centres are found in South Africa (98), followed by Kenya (37).³⁰ Standards and guidelines to regulate the establishment and functioning of rehabilitation services are equally lacking. Any person can set up a rehabilitation home, irrespective of whether they are qualified to do so or not.

16. **Illegal and informal brewing, distilling and sale of alcohol:** Local forms of alcohol are brewed for local consumption and often do not get into the national systems that record consumption through sales and taxes. In addition to this, porous borders and differing tax policies encourage the smuggling of alcohol, which constitutes another challenge.

17. **Interference by the alcohol industry.** This interference delays and impedes the adoption of alcohol policies by **parliament**. The alcohol industry continues to advertise without restrictions,

²⁶ Angola, Benin, Botswana, Central African Republic, Côte d'Ivoire, Equatorial Guinea, Ghana, Madagascar, Malawi

²⁷ Burkina Faso, Burundi, Cameroon, Chad, Comoros, Congo, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Lesotho, Liberia, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Togo, United Republic of Tanzania, Zambia, Zimbabwe

²⁸ Burkina Faso (13 years), Chad (16 years), Congo, (16 years), Côte d'Ivoire (14 years), Mali (15 years).

²⁹ Algeria, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Madagascar, Malawi, Mauritius, Mauritania, Niger, Rwanda, Senegal, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

³⁰ African Union Commission (2023) The Pan African Epidemiology Network on Drug Use. Statistics and Trends on illicit Drug Use, Treatment, demand and supply in Africa 1st January 2016 to 31st December 2021 (Draft)

provides support for sporting events, and even contributes to rehabilitation services under the pretext of “corporate social responsibility”.³¹ Advertisements for alcoholic beverages also continue to run at peak hours of television viewing, including during hours when children, adolescents and young adults may be watching.

18. Influence of alcohol tax revenues on other sectors of government. This is seen especially with the ministry of finance and the ministry for economic development. While there is evidence to show that the harmful effects of alcohol far outweigh revenues from taxes, the benefits of alcohol control are only realized in the long term, 10 or 20 years in the future,³² while the revenues are immediate and tangible. Governments in the African Region have a very narrow tax base and are reluctant to approve policies that may interfere with alcohol tax revenues.

19. Packaging of alcohol in sachets and small-quantity bottles. The alcohol packaged in these forms is affordable to young people, as well as to people in lower income brackets. Such packaging increases access and availability of alcoholic beverages to low-income populations, including children and adolescents.

20. Increasing drug trafficking, growing and distribution. The Region is increasingly targeted as a transit point for drug trafficking, with transit points in east, west and central as well as southern Africa³³. With increased transit, there is increased leakage into the country. Some governments are also encouraging the growing of “medicinal marijuana for export”³⁴, which is accompanied by increased consumption of non-medicinal marijuana³⁵. The Region is also being targeted by and showing an increase in other addictive behaviors, such as online gaming and gambling³⁶.

VISION, GOAL, OBJECTIVES, MILESTONES AND TARGETS

21. Vision: An African Region free from the harmful use of alcohol.

22. Goal: Morbidity, disability, and mortality due to alcohol consumption significantly reduced in the African Region by 2030.

23. The objectives are to:

- (a) increase implementation and enforcement of high-impact policy options and interventions to reduce the harmful use of alcohol in the African Region, taking into account the gender perspective and a life-course approach;
- (b) strengthen multisectoral actions through effective governance, enhanced political commitment, leadership, dialogue and coordination;
- (c) enhance the capacity of health and social care systems to prevent and treat alcohol disorders as an integral part of universal health coverage (UHC) and in alignment with the 2030 Agenda for Sustainable Development and its health targets;
- (d) raise awareness of the risks and harms associated with alcohol consumption and its impact on the health and well-being of individuals, families, communities and nations;

³¹ Babor TF, Robaina K, Brown K, et al: Is the alcohol industry doing well by ‘doing good’? Findings from a content analysis of the alcohol industry’s actions to reduce harmful drinking. *BMJ Open* 2018;8:e024325. doi: 10.1136/bmjopen-2018-024325

³² MOH Kenya (2022) Mental Health Investment Case Report; MOHCC (2022) Zimbabwe Mental Health Investment Case Report (Draft); MOH Uganda (2022) Mental Health Investment Case Report (Draft)

³³ UNODC (2023) World Drug Report ([World Drug Report 2023 \(unodc.org\)](https://www.unodc.org/world-drug-report-2023) accessed 03 July 2023)

³⁴ [Africa eyes the global cannabis market – DW – 04/06/2022](https://www.dw.com/en/africa-eyes-the-global-cannabis-market/dw-04/06/2022); [East Africa could become a major cannabis export hub - The East African](https://www.dw.com/en/east-africa-could-become-a-major-cannabis-export-hub-the-east-african/dw-04/06/2022)

³⁵ UNODC (2023) World Drug Report ([World Drug Report 2023 \(unodc.org\)](https://www.unodc.org/world-drug-report-2023) accessed 03 July 2023)

³⁶ UNODC (2023) World Drug Report ([World Drug Report 2023 \(unodc.org\)](https://www.unodc.org/world-drug-report-2023) accessed 03 July 2023)

- (e) strengthen information systems and research for monitoring alcohol consumption, alcohol-related harm, their determinants and modifying factors, and policy responses at all levels;
- (f) increase the mobilization of resources required for appropriate and sustained actions to reduce the harmful use of alcohol at all levels.

24. **Targets: By 2030**

- (a) at least a 20% relative reduction (against the 2019 baseline) in alcohol per capita consumption;
- (b) 60% of countries have developed and enacted a written stand-alone or integrated national alcohol policy based on the best available evidence;
- (c) 50% of countries have an established national multisectoral coordination mechanism for the implementation and strengthening of national multisectoral alcohol policy responses;
- (d) 50% of countries have developed and or strengthened interventions to reduce the harmful use of alcohol, within and outside the health sector at national level.

25. **Milestones: By 2025:**

- (a) at least a 10% relative reduction (against the 2019 baseline) in alcohol per capita consumption;
- (b) 40% of countries have developed and enacted a written national alcohol policy based on the best available evidence;
- (c) 30% of countries have an established national multisectoral coordination mechanism for the implementation and strengthening of national multisectoral alcohol policy responses;
- (d) 30% of countries have developed and or strengthened interventions to reduce the harmful use of alcohol, within and outside the health sector at national level.

26. **Milestones: By 2028:**

- (a) at least a 15% relative reduction (against the 2019 baseline) in alcohol per capita consumption;
- (b) 50% of countries have developed and enacted a written national alcohol policy based on the best available evidence;
- (c) 40% of countries have an established national multisectoral coordination mechanism for the implementation and strengthening of national multisectoral alcohol policy responses;
- (d) 40% of countries have developed and/or strengthened interventions to reduce the harmful use of alcohol, within and outside the health sector at national level.

GUIDING PRINCIPLES


27. **Evidence-based approach:** Policies and programmes should be based on the best available evidence and sensitive to national contexts.

28. **Empowering of people and communities:** Interventions should include inputs from persons and communities with lived experiences of alcohol-related harm or alcohol use disorders.

29. **Human rights approach:** Interventions to reduce the impact of the harmful use of alcohol should contribute to the fulfilment of the right to the highest attainable standard of health, addressing and eliminating discriminatory practices regarding preventive and curative measures for people with AUDs.

30. **Equity-based approach:** Policies and interventions to reduce the harmful use of alcohol should aim to reduce health inequalities and protect people in different groups. This can be

approached by addressing underlying structural factors including strengthening multisectoral socioeconomic development activities.


31. **Protection from commercial interests:** The utmost priority of interventions should be the public health of the people, and commercial and other vested interests must not be allowed to interfere. 

32. **Multisectoral actions:** The development, implementation and enforcement of alcohol control interventions require concerted multisectoral actions, in a coordinated and strategic manner with the engagement of the health sector and other relevant sectors.


33. **Life-course approach:** Interventions and strategies should protect people at all stages of life, especially the vulnerable, including the unborn child, children and young people.

PRIORITY INTERVENTIONS AND ACTIONS

34. **Establish partnerships and multisectoral coordination mechanisms** to oversee the implementation of the alcohol policy. Sectors within such mechanisms should include health, education, finance and economic development, social welfare, and community development, among others. Leadership and coordination should be done by the highest level of government.


35. **Develop multisectoral alcohol harm reduction policies**, which include health, internal affairs, education, social welfare, and community development. All Member States should specify the legal blood alcohol concentration limit, and ensure that it is equal to or less than 0.05%. They should also establish licensing systems that monitor the production, importation and sale of alcohol. 

36. **Develop and/or strengthen legislation and regulations.** Strong political will should be expressed by the highest level of Government, supporting the development of legislation and regulations. These include measures to limit access, including opening and closing hours, sale of alcoholic beverages to minors, limiting/restricting the sale of alcohol to non-licensed premises such as petrol stations, supermarkets, and kiosks. Production and sale of “home brews” should be regulated.


37. **Increase excise taxes and regularly review prices with regard to inflation and income so that alcohol does not become more affordable over time.** Other strategies include the establishment of minimum prices and restriction of price promotions and discount sales. 


38. **Reduce the public health impact of illicitly or informally produced alcohol**, taking into consideration the differences in strategies to address informally and illegally produced alcohol. This includes activities related to the assessment of the level of unrecorded alcohol consumption in populations, the efficient control of alcohol production and distribution, raising awareness of the associated health risks and community mobilization.


39. **Enforce measures to reduce the acceptability of alcohol:** There should be comprehensive restriction of alcohol marketing, advertising, sponsorships and promotion across all media, including new and emerging media, with appropriate deterrent mechanisms. Sponsorship of youth or educational programmes, including youth and other recreational programmes, by the alcohol industry should be prohibited. The display of alcoholic beverages together with water and other non-alcoholic beverages at the point of sale in supermarkets should be restricted or prohibited, while the labelling of alcoholic beverages to include alcohol content and the harm related to alcohol should be enforced.


40. **Carry out awareness campaigns on the effects of alcohol**, both formally and informally produced, on the individual and the community. Develop programmes to increase awareness on the harms of alcohol use, targeting special populations such as women in the reproductive ages, and drivers of mass transport vehicles. These campaigns should be context specific, such as targeting pregnant women and children and adolescents; and based on the ages and literacy levels of communities. They should be delivered via traditional and digital media channels. 


41. **Reduce the availability of alcohol:** Restrict the times and days of sale of alcoholic beverages, restrict the sale of alcohol in and around educational establishments; restrict the sale of alcohol in and around sporting events and cultural events that include minors; establish a national legal minimum age (18 years or more) for purchase (including online purchase) and consumption of alcohol; regulate the number, density and location of alcohol retail outlets.

42. **Develop programmes to prevent and/or delay initiation of alcohol use, especially among school-going children and adolescents**, in partnership with the education sector and other partners. This can include school mental health clubs that address this issue, peer-led and peer support alcohol prevention programmes in all schools, as well as peer-led social media campaigns that discourage the use of alcohol. 

43. **Provide appropriate infrastructure and funding at all levels for the management of alcohol use disorders:** Establish widespread implementation of screening and brief interventions for early recognition, provision of preventive counselling, and referral to treatment for persons with an alcohol use disorder in primary care settings. Ensure that health services are holistic and integrated, with inputs from people with alcohol use disorders and, where appropriate, including families as part of the recovery process. Establish and support community-based services for follow-up, rehabilitation, and relapse prevention. 

44. **Support capacity building for health professionals**, including health providers working in the areas of noncommunicable diseases and mental health, as well as public health experts. Governments should invest in the training of health care workers so they are able to manage and treat people with alcohol and drug use disorders. This is especially important for primary health care workers, as well as those responsible for vulnerable populations, such as those who manage children and adolescents, people living with HIV, with tuberculosis as well as women in the reproductive ages. 

45. **Capacity building for representatives of civil society organizations**, including mutual help groups and associations of affected individuals and their family members should be carried out so they can effectively advocate for, implement, enforce and sustain the implementation of effective measures to ~~reduce the harmful use of alcohol~~. 

46. **Enforce drink-driving countermeasures:** Establish and enforce upper limits of 0.5  for blood alcohol concentration. Ensure that routine, random breath testing by law enforcement agents is carried out. Ensure that penalties are visible to all and sustained, reflecting the seriousness of the offence (higher penalties for higher BAC levels), while they should be graduated for reoffenders.

47. **Develop or strengthen national or subnational systems for monitoring alcohol consumption** and its socioeconomic modifiers, including affordability and availability, and for evaluating actions taken. Support monitoring and research activities among vulnerable populations such as children and women of childbearing age, as well as on risk and protective factors.

48. Implementation of the priority interventions will be assessed by Member States and progress reports will be presented for review by the Regional Committee **every three years**.

49. **Development of a Strategy to combat the use of drugs and other addictive behaviours in the WHO African Region.** This should take into account the issues specific to the Region and the sub regions, including the high use of opioids in East Africa, higher Cannabis use in the Central and West Africa, the linkage of drug use with HIV, increased trafficking of drugs among other issues.

ACTIONS PROPOSED

50. The Regional Committee is invited to examine and adopt the implementation framework.