Uganda Alcohol Status Report 2026

Towards a healthier Uganda



OCTOBER 2026

UGANDA ALCOHOL POLICY ALLIANCE (UAPA)

UGANDA ALCOHOL STATUS REPORT 2026

GOAL

To inform policies and programmes that reduce alcohol-related harm by bringing together evidence on alcohol use, its health and social impacts, and the measures that can reduce harm in Uganda.

THEME

Using evidence to strengthen alcohol control and protect communities

Kampala, Uganda

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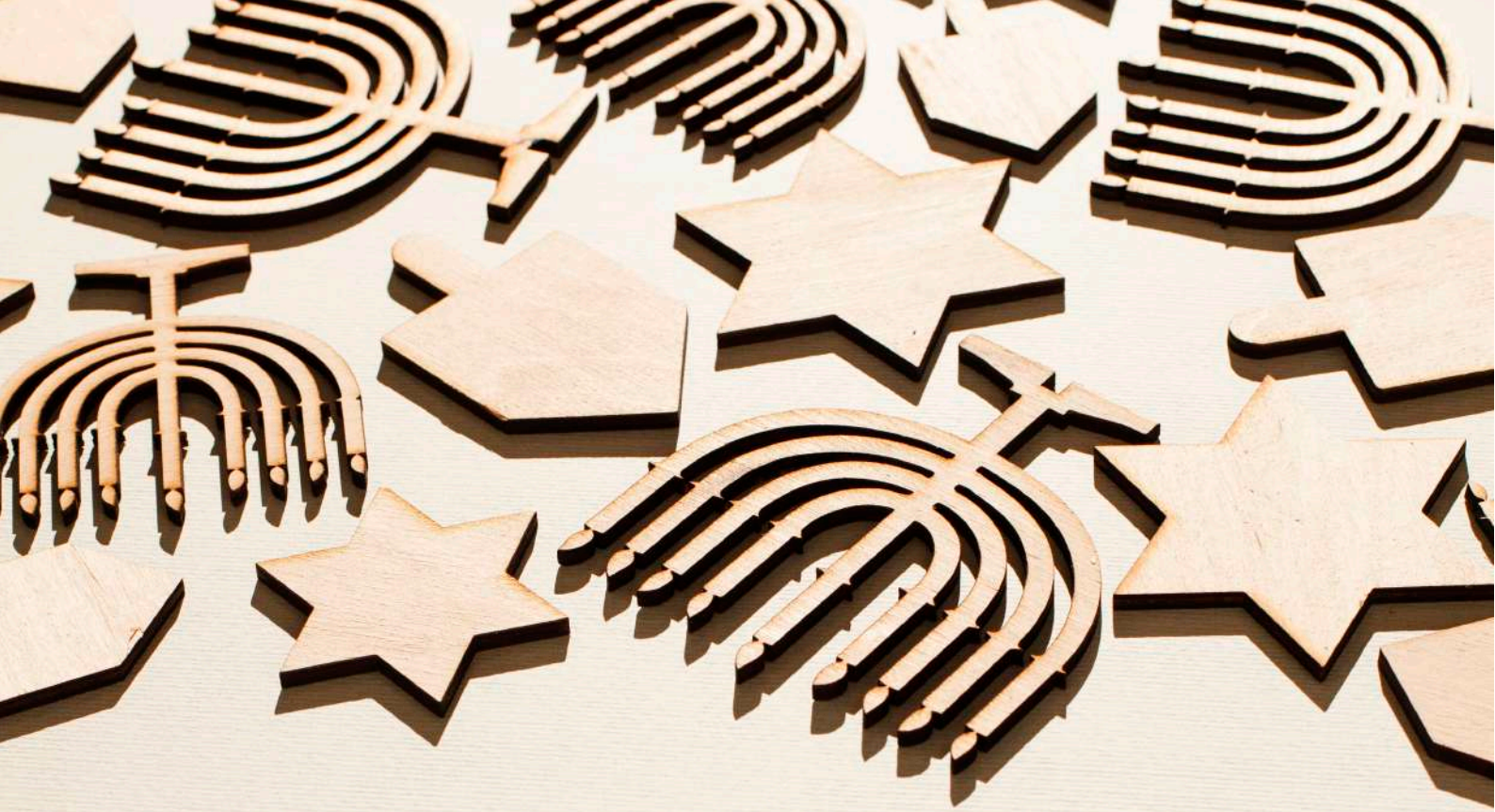
Acronyms

APC	Alcohol Per Capita
ASR	Alcohol Status Report
AUD	Alcohol Use Disorder
AUDIT	Alcohol Use Disorders Identification Test
AUDIT-C	Alcohol Use Disorders Identification Test - Consumption
DALY	Disability-Adjusted Life Year
FAOSTAT	Food and Agriculture Organization Corporate Statistical Database
FASDs	Fetal Alcohol Spectrum Disorders
GAAP	Global Alcohol Action Plan
HED	Heavy Episodic Drinking
HIV	Human Immunodeficiency Virus
IOGT-NTO	International Organization of Good Templars - Nationaltem-plarorden
IPV	Intimate Partner Violence
MoH	Ministry of Health
NOS	Newcastle-Ottawa Scale
PLWH/A	People Living with HIV/AIDS
SAFER	Strengthen, Advance, Facilitate, Enforce, Raise
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SES	Socialeconomic Status
UAPA	Uganda Alcohol Policy Alliance
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
WHO	World Health Organization

Definitions

Alcohol Use Disorder (AUD):	This is a medical condition defined as a problematic pattern of alcohol use that leads to clinically significant impairment or distress. Please note that the WHO classifies problems attributable to alcohol consumption into distinct clinical and behavioral categories of harmful use of alcohol, alcohol dependence and hazardous use.
Harmful Use of Alcohol:	A pattern of alcohol consumption that causes damage to physical or mental health.
Alcohol Dependence:	The World Health Organization (WHO), through the International Classification of Diseases (ICD), defines alcohol dependence syndrome as a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated alcohol use. An alcohol dependence diagnosis is typically established when three or more of the following indicators are present together during the previous year. The indicators include: A strong desire or sense of compulsion, impaired control, withdrawal symptoms, increased tolerance, neglect of alternative interests, and persistent use despite clear harm.
Hazardous use:	A separate non-dependent and non-harmful-yet pattern of alcohol consumption that increases the risk of harmful consequences to the user
Heavy Continuous Drinking (HCD):	Defined as average consumption of at least 60 grams of pure alcohol per day in the last year.
Heavy Episodic Drinking (HED):	Heavy episodic drinking, frequently referred to as binge drinking is defined by the World Health Organization as consuming 60 grams or more of pure alcohol on at least one occasion within the past 30 days. This amount equals roughly six standard alcoholic drinks.
Illicit Alcohol:	This is alcohol that is illegally produced, smuggled, or sold outside regulatory systems, evading taxation and safety controls, often containing harmful substances and posing serious public health risks.
Informal Alcohol:	Refers to traditional brews such as *waragi, malwa, tonto*, and *ajon*, produced at household or community level with no standardized quality control. They are usually unregistered, untaxed, fall outside the usual system of governmental control and are sold in homesteads, backyards and rural trading centers.
Social Harm:	Drinking that results in detrimental health and social consequences for the drinker, the people around the drinker, and society at large.



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Foreword

STATEMENT BY THE
MINISTRY OF HEALTH
REPUBLIC OF UGANDA

The Ministry of Health welcomes the publication of the Uganda Alcohol Status Report 2026. This report provides an important synthesis of evidence on alcohol consumption, alcohol-related harm, prevention and treatment responses, and the policy and regulatory environment in Uganda.

Alcohol-related harm is not limited to the individual who consumes alcohol. It affects families, communities, health services and national development. It contributes to noncommunicable diseases, mental-health conditions, injuries, road traffic crashes, violence, infectious-disease risks, loss of household income and reduced productivity. Children, young people, women, low-income households and communities with limited access to health and social services may experience a disproportionate share of these consequences.

The findings presented in this report require serious attention. The pooled evidence indicates substantial levels of recent alcohol use, heavy episodic drinking among current consumers, and heightened vulnerability in particular populations and settings. The report also draws attention to alcohol use during pregnancy, the interaction between alcohol use and HIV and tuberculosis, widespread informal production, and inadequate access to screening, treatment and rehabilitation services. These trends, coupled with aggressive alcohol marketing, have escalated alcohol use and harm in Uganda.

> **The evidence before us should lead to action. By working together, Uganda can prevent avoidable harm, strengthen healthy families and communities, and secure a healthier future for its people.**

Uganda took an important step by adopting the National Alcohol Control Policy in 2019. However, a policy achieves its purpose only when it is adequately financed, implemented, monitored, and supported by an effective legal and institutional framework. The finding that only a small proportion of districts have operational alcohol regulations or by-laws highlights the need to strengthen the connection between national policy and local implementation.

The Ministry of Health recognizes that preventing alcohol-related harm requires coordinated action across government and society. Priorities include strengthening alcohol legislation; integration; strengthening surveillance; protecting children from alcohol marketing and availability; and supporting enforcement.

I commend the Uganda Alcohol Policy Alliance, the researchers, contributing institutions and stakeholders who supported the preparation of this report. I encourage Ministries, Departments and Agencies, local governments, Parliament, development partners, academia, civil society, cultural and religious institutions, the media and communities to use its findings to inform planning, investment and accountability.

The evidence before us should lead to action. By working together, Uganda can prevent avoidable harm, strengthen healthy families and communities, and secure a healthier future for its people.



Dr. Hafsah Lukwata
Assistant Commissioner
Health Services
Mental Health & Control of
Substance Use.
Ministry of Health

STATEMENT BY THE CHAIRPERSON, UGANDA ALCOHOL POLICY ALLIANCE



Turning Evidence into Action to Prevent Alcohol Harm and Save Lives

It is my honour to present the Uganda Alcohol Status Report 2026, a national evidence resource developed to strengthen understanding, policy action and public accountability concerning alcohol-related harm in Uganda.

The Uganda Alcohol Policy Alliance commissioned this report because effective advocacy must be grounded in credible evidence. Uganda has accumulated important research, programme experience and administrative information on alcohol consumption and its consequences. However, this evidence has often remained dispersed across academic publications, government reports, civil-society records and institutional databases. This report brings those sources together to provide a more coherent picture of the country's alcohol situation.

The findings demonstrate that alcohol-related harm is a public-health, social justice and development concern. Harmful alcohol use is associated with disease, injury, violence, mental-health challenges, household impoverishment, poor treatment outcomes and lost productivity. The effects extend beyond people who consume alcohol to children, partners, road users, workplaces and entire communities.

> **We invite every stakeholder to treat this report as a call to action. Its value will not be measured by the number of copies distributed, but by the policies strengthened, services expanded, communities protected and lives saved.**

The report also reveals a substantial gap between Uganda's policy commitments and implementation. Although the National Alcohol Control Policy provides a foundation for action, enforcement remains fragmented and inadequately resourced. Most districts do not have operational alcohol regulations; comprehensive national legislation remains necessary; access to screening and treatment is limited; and children and young people continue to be exposed to alcohol availability and marketing.

Nevertheless, this report is not simply a record of problems. It presents a practical agenda for change. Uganda can reduce alcohol-related harm by adopting and enforcing comprehensive legislation, strengthening taxation and pricing measures, regulating alcohol availability and marketing, expanding screening and treatment services, improving drink-driving enforcement, supporting district ordinances, addressing unsafe informal alcohol and investing in reliable national surveillance and research.

As civil society, we recognise our responsibility to translate evidence into sustained public education, policy engagement, community mobilisation and accountability. We must strengthen collaboration among civil-society organisations and work constructively with government, academia, health professionals, development partners, cultural and religious leaders, the media and affected communities. Such collaboration must remain transparent and protected from alcohol-industry interference and other conflicts of interest.

On behalf of the UAPA Board and membership, I express sincere appreciation to the researchers, editorial team, technical contributors, member organisations and stakeholders who participated in the consultations and validation of this report. We particularly recognise the Ministry of Health and other government institutions whose policy leadership and data are essential to an effective national response.

We invite every stakeholder to treat this report as a call to action. Its value will not be measured by the number of copies distributed, but by the policies strengthened, services expanded, communities protected and lives saved.

Together, we can advance evidence-based alcohol control and move Uganda towards a future free from preventable alcohol-related harm.



Dr. Ruth Kikome
Chairperson
Uganda Alcohol Policy Alliance

IMPACT SNAPSHOT

ASR 2026 AT A GLANCE

54.5%

of current drinkers in Uganda are Heavy Episodic Drinkers (HED).



23.5%

of adolescents aged 15-19 years are current alcohol drinkers globally.



12.4%

is the estimated pooled AUD prevalence in Uganda, much higher than the global rate of 7.0% and the African region rate of 6.3%.



9.8%

of women globally reported alcohol use during pregnancy.



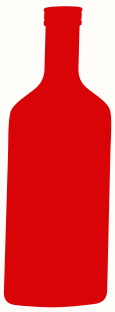
40% to 50%

of PLHIV globally have a documented lifetime history of alcohol abuse or dependence.



12.2 Litres

is Uganda's current APC, up from 11.3L in 2020, placing it among the highest in Africa. The APC was projected to reach 12.0L in 2025 and 9.9L in 2030.



71.7% men & 62.4% women

in Karamoja region took at least one drink in the last month; the region with the highest alcohol consumption in Uganda.



Executive Summary

Background:

Uganda is one of the countries that bears the highest burden of harmful alcohol use within the WHO African Region. The Uganda Alcohol Status Report (ASR) 2026 presents national-level insights on alcohol consumption trends, associated harm and policy implementation status, and offers recommendations.

Methods:

This report was developed through a consultative process involving a team of experts and later reviewed by stakeholders in policy advocacy, alcohol harm prevention, academia, and the media. The methodology benchmarked relevant reports and studies. A systematic literature review followed PRISMA 2020 guidelines. We searched five electronic databases and grey literature. We assessed quality using the Newcastle–Ottawa Scale (NOS) and the Cochrane Risk of Bias (RoB) tool. This report also evaluated 17 grey-literature documents, including WHO and Government of Uganda publications and alcohol-related research studies. The findings were synthesized to produce a representative national-level alcohol status report.

Results:

Data on prevalence of alcohol use in Uganda vary considerably depending on the source. WHO reports indicate a prevalence rate of 42.6% among those aged 15 years and above. Pooled overall prevalence of past-month alcohol use in the studied literature and from the Uganda Demographic and Health Survey (UDHS) report was established at 33.7% and 26.8%, respectively. Specific research in particular subgroups such as fishing communities (45% - 52%), with significantly higher rates of hazardous drinking than in agrarian and trading areas.

Alcohol use among people living with HIV (PLHIV) was also generally higher at 33% - 50% compared to the general public. All data sources found higher prevalence in males than females; pooled data (males: 46.1%; females: 15.3%). Heavy Episodic Drinking (HED) among current drinkers was found to be 54.5%. Key determinants of alcohol consumption included being male, low socioeconomic status (SES), lower education, having a positive HIV status, living in fishing communities, and proximity to alcohol outlets.

As indicated in earlier studies, alcohol was associated with HIV risk, intimate partner violence (IPV), tuberculosis, and poor mental health. Uganda has embraced the WHO SAFER initiative, a framework of evidence-based measures to prevent alcohol harm.

Conclusion and Recommendations:

This study confirmed that alcohol consumption in Uganda is highly prevalent, deeply embedded in social and economic contexts, and associated with a broad spectrum of health and social harms. The existing policy framework is still inadequate, and implementation is critically deficient. Uganda's trajectory of declining alcohol consumption and attributable deaths demonstrates that progress is possible but requires consistent and strong political will, adequate resourcing, and multisectoral action for sustained and significant impact.

Findings of the 2026 Alcohol Status Report highlight several priorities that could be pivotal in the fight against alcohol harm. Identified data support strategies that target the pattern, not just the pint, tackle heavy episodic and informal drinking behaviors, prioritize alcohol prevention for high-risk groups, address the rising alcohol use among women, build momentum for the declining trends of alcohol consumption.

Keywords:

alcohol consumption; Uganda; systematic review; meta-analysis; prevalence; determinants; interventions; Sub-Saharan Africa.

1 Global and African Region Trends in Alcohol use



1.1 Introduction

This report provides insight into the alcohol use situation in Uganda and its effects as documented in the recent literature. The introduction provides an overview of the global alcohol situation.

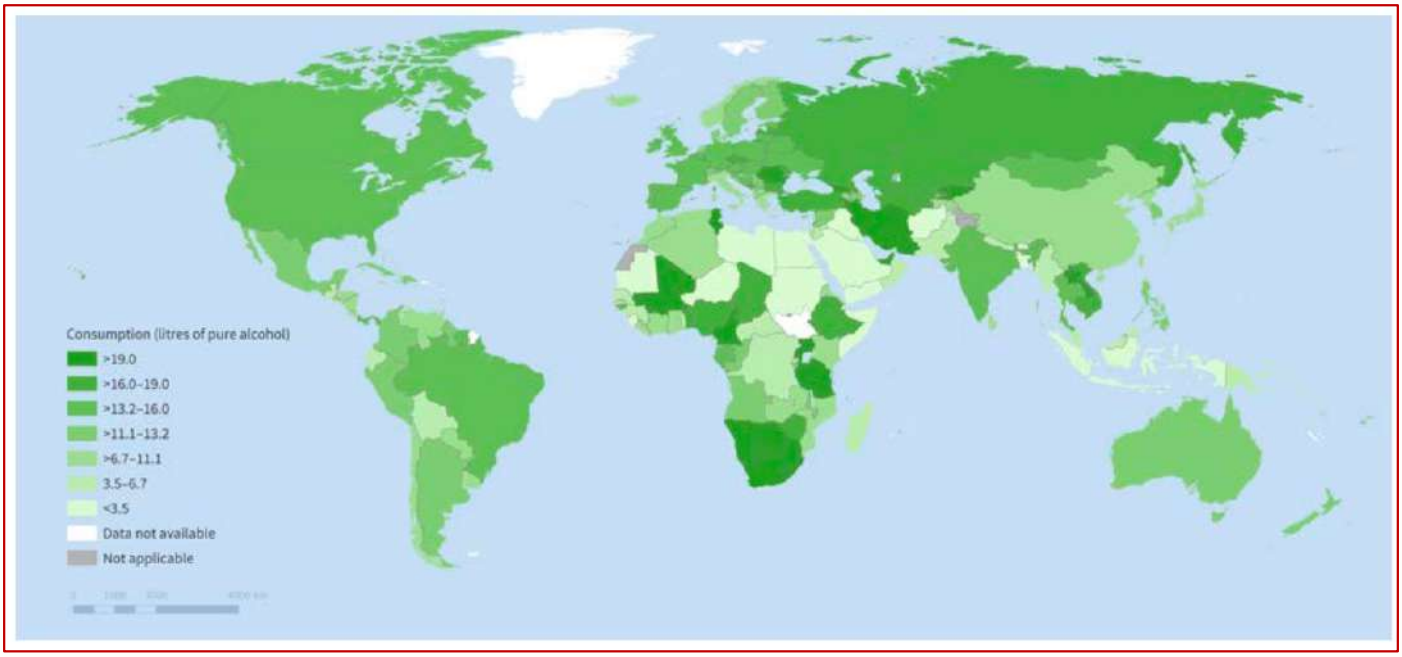
1.2 Global and Regional Trends

The World Health Organization (WHO) Global status report on alcohol and health and treatment of substance use disorders (2024) reports a global average consumption of 27 grams per day for each drinker globally. The alcohol per capita (APC) in the world's population aged 15+ years generates an estimate of 12 grams of pure alcohol per day for each person aged 15+ years.

However, the total alcohol per capita (APC) consumption in the world decreased slightly from 5.7 litres in 2010 to 5.5 litres among the population aged 15 years and older. Despite the declining trends, the prevalence of alcohol consumption among the 15–19-year-old population is unacceptably high worldwide, accounting for 22% (WHO, 2024).

Figure 1 below shows the global distribution of total alcohol per capita (APC) consumption among drinkers aged 15 years and older (WHO, 2024).

Total alcohol per capita (APC) consumption among drinkers aged 15 years and older, 2019.



Reproduced from WHO (2024)

Among those who consumed alcohol, men consumed more than women (2.9L vs 1.6L globally on a population basis). Figure 2 below shows an overview of total (recorded and unrecorded) APC globally by WHO region.

Figure 2: Total recorded and unrecorded alcohol per capita (APC) consumption for 15+ years in liters of pure alcohol by WHO Regions, 2019.



Reproduced from WHO (2024)

Key: AFR = African Region; AMR = Americas Region; EMR = Eastern Mediterranean Region; EUR = European Region; SEAR = South-East Asia Region; verify and apply the official WHO regional label; WPR = Western Pacific Region (WHO regional designation).

Unrecorded alcohol consumption accounted for 21% of total consumption worldwide, and overall, the wealthier a country or region, the higher the level of consumption and the lower the proportion of unrecorded consumption.

In the WHO African Region, total alcohol per capita (APC) declined from 6.3 litres in 2016 to 4.8 litres, though this regional average conceals substantial heterogeneity.

1.3 Global Alcohol Consumption in Subgroups

1.3.1 Alcohol Use among Young People

According to the WHO Global status report on alcohol and health and treatment of substance use disorders (2024), 23.5% of adolescents aged 15-19 years are current alcohol drinkers. Young people aged 20-39 years were the highest proportion (13.0%) of alcohol-attributable deaths (WHO, 2024).

1.3.2 Alcohol Use in Urban vs Rural areas

The general alcohol access and wider variety of commercial beverages are typically higher in urban areas, while the severity of hazardous drinking patterns and alcohol-attributable harm is disproportionately worse in rural and remote communities (WHO, 2024).

1.3.3 Alcohol Use in the Fishing Communities

Coulthard et al. (2020) report relatively higher alcohol consumption among fishing communities. For instance, in India (Kerala/South), up to 88% of fishermen report active alcohol consumption, with around 40% classified in harmful drinking zones. In West Africa (Elmina, Ghana), about 59.2% of fishers report alcohol indulgence, while 48.5% engage in binge drinking. Finally, in Europe, France reported lower but still elevated hazardous drinking of around 18.6%. According to Coulthard, leading risk factors for high alcohol use in fishing communities include harsh working conditions (such as constant exposure to cold weather, high physical fatigue, long working hours, and life-threatening risks at sea), emotional or physical stress (such as managing loneliness during extended isolation away from home), and socioeconomic demographics, including lower formal education, younger age brackets, and dominance of the male gender.

1.3.4 Alcohol Use among People living with HIV/AIDS

Alcohol misuse is significantly elevated among people living with HIV/AIDS (PLWH/A) compared to the general population. Globally, PLWH/A are two to six times more likely to experience alcohol use disorders (AUD) or engage in hazardous drinking than those without the virus (Duko et al., 2019), and 40% to 50% have a documented lifetime history of alcohol abuse or dependence (Giamo and colleagues, 2025).

1.3.5 Alcohol Use among Expectant Mothers

Alcohol use during pregnancy is a critical global public health concern, with no known safe amount, type, or timing of consumption. Yet a meta-analysis published in The Lancet estimated the global prevalence of alcohol use during pregnancy at 9.8%. The WHO European Region has the highest rates globally, with 16% to 25% of pregnant women estimated to consume alcohol. The UK (about 41%) stands out as having one of the highest rates globally (Ujhelyi et al., 2022). A systematic review and meta-analysis by Andualem (2025) placed the pooled prevalence of alcohol use among pregnant women in Africa at 28.33%.

1.3.6 Alcohol Use and Socioeconomic Status

According to WHO (2021), in their report "Addressing alcohol consumption and socioeconomic inequalities: how a health promotion approach can help," people from lower socioeconomic groups drink more heavily on drinking occasions, engage in other health risk behaviors, and have lower access to health services. Drinking patterns and health behaviors explain some, but not all, of the outcomes experienced by those with fewer resources. People with lower socioeconomic status tend to suffer disproportionately compared to people with higher socioeconomic status.

1.4 Harmful Use of Alcohol

WHO defines the "harmful use of alcohol" as a pattern of alcohol consumption that causes damage to physical or mental health. Harmful use of alcohol causes detrimental health and social consequences for the drinker, the people around the drinker, and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes (WHO, 2010a).

1.4.1 Heavy Episodic Drinking (HED)

HED is defined as consuming at least 60 grams of pure alcohol on one or more occasions in the preceding month. WHO estimates 38% of current drinkers to be engaged in heavy episodic drinking (HED). Continuous heavy drinking was highly prevalent among men, accounting for 6.7% of male drinkers globally.

1.4.2 Alcohol Use Disorders:

Globally, the prevalence of AUDs decreased from 7.8% in 2010 to 7.0% in 2019, and the prevalence of alcohol dependence decreased from 4.1% in 2010 to 3.7% in 2019. The prevalence of AUDs increased in the African Region (8.8% relative increase), Eastern Mediterranean Region (6.9% relative increase) and the South-East Asia Region (5.3% relative increase). (WHO, 2024).

1.4.3 Alcohol-related Harm

Alcohol use remains a leading modifiable risk factor for mortality and morbidity globally. In 2019, alcohol consumption was responsible for 2.6 million deaths, 4.7% of all deaths that year. Of these, approximately 2 million deaths occurred among men and 0.6 million among women (WHO, 2025). The burden was highest in the WHO European and African Regions, at 52.9 and 52.2 deaths per 100,000 population, respectively. Globally, in 2019, alcohol use disorders (AUDs), alcohol poisonings and fetal alcohol syndrome (FAS) caused an estimated 156,000 deaths (representing 6.0% of all alcohol-attrib-

utable deaths) and 19.3 million DALYs lost (representing 16.6% of all alcohol-attributable DALYs lost).

According to the WHO (2025), "the global burden of disease and injuries caused by alcohol consumption can be quantified for 31 health conditions based on available scientific evidence for the role of alcohol use in their development, occurrence and outcomes". In 2019, harmful use of alcohol was responsible for 873,804 Disability-Adjusted Life Years (DALYs).

The prevalence of AUDs also showed a large variation by sex, with 264 million males aged 15 years and older (9.3% of all males in this age category) and 136 million females aged 15+ years (4.8% of females in this age category) having an AUD. For males, the highest prevalence of AUDs was observed in the African Region (13.5% of males 15+).

1.4.4. Alcohol and Cancer

Globally, different types of cancer had varying alcohol attributable fractions (AAFs) for selected causes of death, disease and injury. According to the WHO Global status report on alcohol and health and treatment of substance use disorders (2024), laryngeal cancer accounted for an alcohol-attributable fraction of deaths of 21%, esophagus cancer had 18%, colon and rectum cancer 12%, liver cancer 11%, and breast cancer 4%. Relatedly, laryngeal cancer had AAFs of DALYs of 21%, oesophageal cancer had 19%, colon and rectum cancer 12%, liver cancer 10%, breast cancer 4% and cervical uteri cancer 1%.

1.4.5. Harm to Others:

According to the Global Alcohol Action Plan (GAAP) 2022-2030 report of 2024, the impact of harmful use of alcohol on health and wellbeing is not limited to health consequences for the user, but it incurs significant social and economic losses relating to costs in the justice sector, lost workforce productivity and unemployment, and the costs as a result of pain and suffering (GAAP, 2024). Some of the most common ways harm is experienced by people other than drinkers are road traffic accidents and consequences of prenatal alcohol exposure that may result in the development of Fetal Alcohol Spectrum Disorders (FASDs). As such, the harm to others varies greatly, some being physical harm, for example, injuries and fatalities as a result of road traffic accidents, being beaten, and others being less tangible, for example, ill health and poor livelihoods, and social consequences like being abused, harassed, and insulted, among others.

1.5 The Alcohol Global Policy and Advocacy

Alcohol is the only psychoactive and dependence-producing substance with a significant impact on global population health that is not regulated at the international level by a legally binding instrument. All other major psychoactive substances are subject to international treaties.

The Global Strategy to Reduce the Harmful Use of Alcohol was endorsed by the Sixty-third World Health Assembly in May 2010 (resolution WHA63.13) and remains the primary global policy framework for addressing alcohol-related deaths and disability across mental health, non-communicable diseases, infectious diseases, and injuries. It recommends a portfolio of policy options covering pricing, marketing, availability, health services response, and monitoring, adjustable to national circumstances, including cultural, religious, and resource contexts.

Progress under this framework has been limited. According to the WHO (2024), the number of countries adopting national alcohol policies has increased slightly, but countries have made little progress in

implementing high-impact policy interventions proven to reduce alcohol-related harm, such as pricing policies or comprehensive marketing and availability restrictions.

The strategy outlines key components for global action and recommends a portfolio of policy options and measures that could be considered for implementation and appropriately adjusted at the national level. The policy options consider circumstances such as cultural and religious contexts, national public health priorities, availability of resources, capacities and capabilities. The strategy also provides a set of principles that should guide the development and implementation of policies at all levels.

1.5.1 WHO SAFER Framework

To fast-track implementation of the GAAP, WHO launched the SAFER initiative, a technical package of five cost-effective strategies to reduce alcohol-related harm. The acronym **S-A-F-E-R** breaks down into the following high-impact strategies:

S – Strengthen restrictions on alcohol availability: Regulate the physical sale of alcohol by managing commercial density, restricting sale hours and days, establishing minimum legal drinking ages, and limiting sales at public events.

A – Advance and enforce drink-driving countermeasures: Implement strict blood alcohol concentration (BAC) limits, enforce random breath testing checkpoints, and establish administrative license suspensions for violations.

F – Facilitate access to screening, brief interventions, and treatment: Integrate standardised screening tools (like the AUDIT-C test) into routine healthcare encounters to identify hazardous use and provide accessible treatment for severe Alcohol Use Disorders (AUD).

E- Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion: Curtail the reach of alcohol marketing across print, broadcast, and digital platforms to protect youth, adolescents, and abstainers from commercial pressure to drink.

R – Raise prices on alcohol through excise taxes and pricing policies: Use specific excise taxes and minimum unit pricing (MUP) to reduce overall population consumption while generating government revenue to match the other strategy descriptions.

The WHO Global Status Report 2024 highlighted that the percentage of countries reporting a written national alcohol policy has increased by 13% over the last decade. It was also noted that most countries implement alcohol excise taxes, but alcohol advertising and marketing on the internet, especially through social media, is growing rapidly and remains largely unregulated. Moreover, internet and social media marketing crosses national borders, pointing to the need for supplementing country-level measures with regional or global approaches (WHO, 2022).

1.5.2 Barriers to the Global Alcohol Policy Development

The WHO Global Status Report 2024 further highlighted that lower-income countries, unlike high-income countries, frequently reported insufficient resources devoted to alcohol policy and the inability to monitor alcohol consumption and its related harms. They also lack national written alcohol policies, which is one of the most important barriers and setbacks to alcohol policy development since 2016. In addition, member states in the WHO Africa region continued to report interference from the alcohol industry in alcohol policy development. In 2019, data revealed that 2

in every 5 people lived in a country that reported such interference over the past three years.

1.5.3 African Region Policy on Prevention of Harmful Use of Alcohol

While much of alcohol consumption occurs in sub-Saharan Africa, the region reported only 41 countries with written national alcohol policies (WHO, 2025). Following the endorsement of the WHO Global strategy to reduce the harmful use of alcohol strategy, regional action plans aligned with the strategy were developed or revised and adopted at WHO Regional levels. The Regional strategy for reducing the harmful use of alcohol was developed and adopted in the WHO Africa Region in 2013 (WHO, 2024). The WHO Global strategy to reduce the harmful use of alcohol.

The East African Community (EAC) recognizes the need to prevent the harmful use of substances, including alcohol and drugs. One of the strategic objectives in the East African Community Health Sector Strategic Plan 2024 – 2030 is to strengthen and sustain the prevention and control of communicable and non-communicable diseases in the EAC region. The EAC targets that all partner states, including Uganda, have adopted and are implementing the EAC strategies on prevention and control of drug abuse and harmful use of alcohol and are covered by treatment interventions (pharmacological, psychosocial, rehabilitation and aftercare) for substance use disorders by June 2030 (EAC, 2024).

1.6 Treatment of Alcohol Use Disorders

WHO Global Status Report highlighted that AUDs treatment is either limited or unaffordable for almost half a billion people worldwide who live with alcohol or drug use disorders. While almost all countries provide some form of treatment infrastructure, adequacy and standards vary widely, and formal government oversight remains low (WHO, 2024). For instance, of the reporting countries, 54% have established national guidelines or standards specifically governing specialized treatment services for alcohol use disorders, and only 46% have active legal regulations in place designed to protect the strict medical confidentiality of individuals enrolled in alcohol rehabilitation or treatment programs.

The percentage of countries with active programs stands in stark contrast to actual patient access. The proportion of people with active AUD who ever make contact with treatment services caps out at a maximum of 14%. A global systematic review of health systems notes that roughly 1 in 6 people (17.3%) suffering from AUD worldwide will ever receive treatment during their lifetime (Mekonen et al., 2021). In low- and lower-middle-income countries, the treatment rate drops heavily to less than 10%, highlighting a severe deficit in programmatic access, specialized staff, and medication coverage. In many countries, treatment programs are linked only to a few leading national institutions or research programs, usually located in cities, with limited capacity and often inaccessible to people living in rural areas.

Sustainable Development Goal (SDG) Target 3.5 seeks to help bridge this divide. This initiative tracks how effectively countries are integrating alcohol screenings, brief behavioral interventions, and pharmacological therapies directly into routine primary healthcare environments rather than keeping them isolated in scarce, specialized psychiatric hospitals.

The WHO Global status report on alcohol and health and treatment of substance use disorders (2024) noted that without accelerated action, progress towards SDG target 3.5, which calls on countries to strengthen the prevention and treatment of substance use disorders, including the harmful use of alcohol, remains off track.

2 Alcohol Use in Uganda



2.1 Context and Rationale for this Report

Globally, Uganda is one of the countries with the highest total alcohol per capita (APC) consumption. Additionally, Uganda is one of the countries with the highest burden of alcohol use in Africa and globally. This burden is compounded by the composition of consumption: illicit brews, including homemade waragi, malwa, and tonto which place most consumption beyond the reach of quality control, taxation, and regulatory oversight. The health risks associated with alcohol are acute, and several fatal methanol poisoning incidents have been documented across Uganda over the past two decades (Birungi et. al., 2020) & (Zavuga, R. et. al., 2023). Yet Uganda's policy response has fallen short of this burden. Against the backdrop of high consumption and a fragmented policy environment, this report seeks to consolidate that evidence systematically to support informed policy and programmatic action.

2.2 Aim of the Report

This report aims to provide a comprehensive, evidence-based assessment of alcohol consumption, related harm, and the policy and intervention landscape in Uganda as of 2026, to inform national action on alcohol control.

2.3 Objectives of the Report

The specific objectives of this report are to:

1. Synthesize existing published and grey literature evidence on the patterns, prevalence, determinants, and trends of alcohol consumption in Uganda.
2. Document the health, social, and economic consequences of harmful use of alcohol in Uganda.
3. Document the prevention interventions, treatment of alcohol-related harm, and institutional responses.
4. Map progress in alcohol policy and legislation, identifying implementation gaps, regulatory weaknesses, and barriers to effective alcohol control.
5. Provide evidence-based recommendations for government, development partners, and other relevant stakeholders to strengthen alcohol control policy, expand treatment access, and reduce alcohol-related harm in Uganda, including evidence-based interventions and policy priorities for alcohol control.
6. Publish the alcohol situational report in international peer-reviewed journals.

3 Methodology



This section reports on the research questions, study design, data collection, analysis, reporting, and concludes with the reliability and validity measures.

3.1 Research Questions

The review was guided by the following overarching question: What is the current evidence on the patterns, determinants, health and social consequences, and policy and intervention responses to alcohol use in Uganda? The following sub-questions structured the evidence synthesis:

3.1.1. What are the prevalence and patterns of alcohol consumption in Uganda?

3.1.2. What are the documented health, social, and economic consequences of harmful alcohol use in Uganda?

3.1.3. What interventions have been implemented to reduce harmful use of alcohol in Uganda, and what is the evidence of their effectiveness?

3.1.4. What is the state of alcohol policy and legislation in Uganda, and what are the key implementation gaps?

3.2 Study Design

This report is based on a desk review of published and grey literature on alcohol use, related harm, and the policy and intervention landscape in Uganda. The study adopted a mixed-methods approach involving documentary review, interviews, and validation meetings with key stakeholders about trends in alcohol use, impact, and legislative progress in Uganda.

3.2.1 Documentary Review:

The scope involved reviewing relevant national data sets, legal frameworks, and institutional reports. The search was conducted between January and March 2026. The assignment focused on national-level sources of literature, as well as regional and global literature, in line with Uganda's alcohol situation, consumption trends, and related harms.

3.2.2 Systematic Literature Review

The systematic review was conducted in accordance with the framework proposed by Arksey and O'Malley (2005) and refined by Levac et al. (2010) and is reported following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR; Tricco et al., 2018). A subsidiary random-effects meta-analysis was conducted on the subset of included studies providing extractable prevalence data. The systematic literature review followed PRISMA 2020 guidelines. Five electronic databases and grey literature were searched, including PubMed, Google Scholar, EMBASE, CORE, and Science.gov.

This comprehensive search was conducted between January and March 2026. No date restrictions were applied to the database search to capture the full historical scope of evidence on alcohol use in Uganda. Search terms were combined using Boolean operators (AND, OR) and included: "alcohol consumption", "harmful alcohol use", "heavy episodic drinking", "binge drinking", "alcohol use disorder", "alcohol dependence", "alcohol policy", and "alcohol prevention", each combined with "Uganda" and, where relevant, "East Africa".

3.2.3 Grey Literature Review

The comprehensive search was supplemented by grey literature sources. A list of grey-literature documents was generated in consultation with the study team (See section of authors and co-authors). The focus of grey literature was mainly on consumption trends and a review of policy and legislative progress on alcohol control in Uganda. Most of the identified results come from WHO, Uganda Bureau of Statistics (UBOS), Ministry of Health (MoH), Uganda Alcohol Policy Alliance (UAPA), and IOGT-NTO. Reference lists of key included studies were also screened to identify additional eligible sources. Priority sources that were used are listed in Table 1.

Table 1: The key documents that were prioritized for grey literature review

No:	Title of Document	Source/Category
1.	Global status report on alcohol and health and treatment of substance use disorders.	WHO
2.	Uganda Alcohol Status Report 2022, and 2020	UAPA
3.	UAPA Annual Reports: 2022, 2023, 2024	UAPA
4.	The Alcohol Situation Assessment Report 2022, 2023, 2024	MoH and IOGT-NTO
5.	Program Reports of UAPA Member Organizations	UAPA Member Organizations
6.	Alcohol Status Report	UAPA
Additional Data Sources Included		
7.	National Alcohol Control Policy (2019)	Ministry of Health
8.	Alcoholic Drinks Control Bill (2023/2024)	Parliament of Uganda
9.	District ordinances	District Local Governments

10.	Uganda Bureau of Statistics (DHS, UNHS, abstracts)	UBOS
11.	Ministry of Health (HMIS, NCD, morbidity/mortality reports)	MoH
12.	Uganda Police (annual crime reports, road safety report 2023 and 2024)	Uganda Police
13.	Licensing protocols and standards documents	Uganda National Bureau of Standards (UNBS)
14.	Documents from other relevant ministries (Gender, Education, Trade, Finance, Local Government, Justice, Uganda Communications Commission)	Ministries, Departments, and Agencies
15.	Other relevant sources: in the EA Region (e.g., NACADA, Movendi International)	NACADA, Movendi International, Assorted sources
16.	WHO Key indicators including alcohol drinking prevalence, burden of harm, economic cost estimates, and enforcement trends.	WHO and MoH
17	World Bank Annual Report 2024	World Bank Group

3.2.4 Inclusion and Exclusion Criteria of the Documentary Review

Titles and abstracts of all records retrieved from the database search were independently screened by two reviewers, with full-text review conducted for all records meeting the inclusion criteria at the title and abstract stage. Discrepancies were resolved by consensus. Studies were eligible for inclusion if they: (a) reported primary data or policy analysis related to alcohol use in Uganda or were multi country studies with extractable Uganda-specific data; (b) were published or produced in English; and (c) focused on any aspect of alcohol consumption, harm, intervention, or policy relevant to the review sub-questions. Studies were excluded if they contained no Uganda-specific data, had no alcohol focus, or were editorial or opinion pieces without primary evidence. Grey literature sources were assessed for relevance by the study team and included if they met equivalent criteria. The full selection process is summarized in the Findings section.

1,847

records were identified via PubMed, Google Scholar, EMBASE, CORE and Science.gov.

142

additional records were identified from grey literature, including WHO, UBOS, MoH and UAPA.

3.3 PRISMA Study Selection of the Systematic Review

The selection process identified the studies and records to be included, screened those records to remove duplicates, and assessed them against the exclusion criteria for articles without data on Uganda and not focusing on alcohol. Up to 1,847 records were identified via PubMed, Google Scholar, EMBASE, CORE, and Science.gov. An additional 142 records were identified from grey literature, including the WHO, Uganda Bureau of Statistics (UBOS), Ministry of Health (MoH), and Uganda Alcohol Policy Alliance (UAPA).

After the process of screening, duplicates were removed, and a total of 1,543 records remained. Furthermore, exclusion screening was conducted based on the title and abstract of each record, leaving 326 as full-text eligible records. Out of the 326 full-text eligible records, additional articles were excluded based on “no Uganda data”, “no alcohol focus”, and editorial opinion. Finally, the records that were eligible and included in the qualitative synthesis for systematic review were 231, and 48 studies were included in quantitative synthesis. (Further details are available on request)

1,543

records remained after the process of screening and removing duplicates.

231

records were eligible and included in qualitative synthesis for systematic review.

3.4 Data Analysis and Reporting

A standardized data charting form was used to extract the following information from each included source: author(s) and year; study design; setting and population; alcohol measure(s) used; and key findings relevant to the review sub-questions. Grey literature sources were charted separately and synthesized narratively alongside the peer-reviewed evidence.

48

studies included in the quantitative synthesis.

For peer-reviewed studies providing extractable prevalence estimates, a random-effects meta-analysis (DerSimonian and Laird) was conducted to pool prevalence estimates. The meta-analysis focused on the prevalence and patterns of alcohol consumption in Uganda, determinants and associated risk factors, health and social consequences, and the effectiveness of interventions to reduce alcohol related harm. Through comparative benchmarking, the inhibitors to alcohol harm reduction against the strategies for reducing alcohol consumption prevalence and related harm were evaluated. Based on the findings, the enablers for reducing alcohol harm were recommended. Accessibility to alcohol harm reduction and the strategies for reducing alcohol consumption prevalence and related harm were evaluated.

3.5 Data from Grey Literature

This report relies heavily on summarized data extracted from the WHO Global Status Report for alcohol and health and treatment of substance use disorders, 2024. The data are a collection of different parameters used to estimate trends and use of alcohol and related harm.

3.6 Validation Meetings

To strengthen the credibility and contextual relevance of the findings, stakeholder validation meetings were convened by the Uganda Alcohol Policy Alliance (UAPA) between March and June 2026. The validation workshop, which comprised 45 participants, included stakeholders and implementing partners active in alcohol harm prevention, treatment, academia, policy and alcohol regulation in Uganda. Feedback was summarized and used to improve and finalize the report. (Details are available on request).

3.7 The Experts Committee

The experts who supported the development of this report comprised of the lead consultant, Mr. Francis Nsanga, and five other experts, including Dr. David Kalema, Prof. Nazarius Mbona Tumwesigye, Dr. Aloysius Rukundo, Dr. Alfred Jatho, and Mr. Daniel Ssekabojja. The team of experts guided the methodology that was adopted, set the objectives of the study, and guided the structure of the report. They also participated in the validation meetings, reviewed and provided input to the draft and final report.

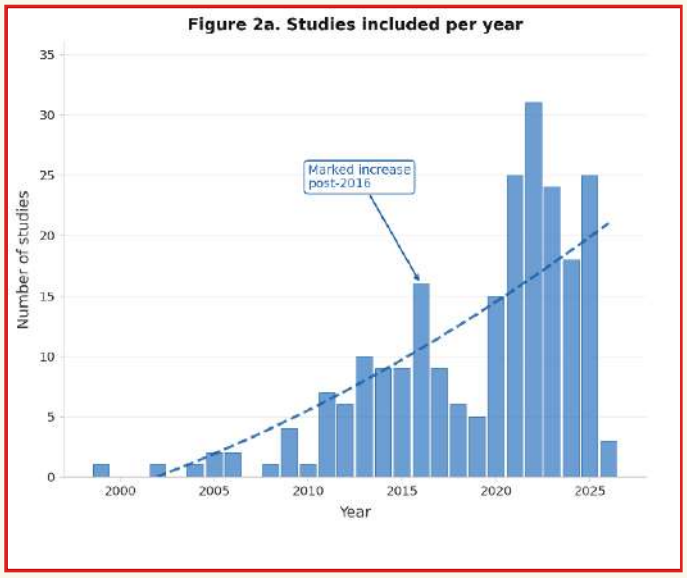
4 Findings Regarding the Alcohol Situation in Uganda

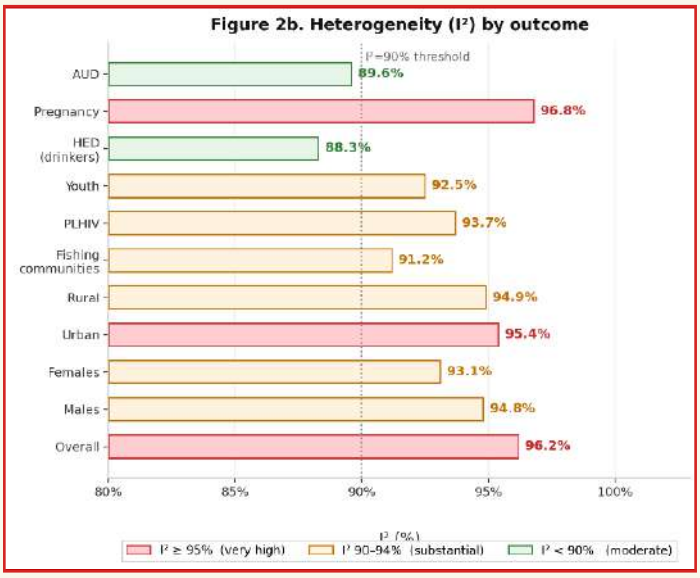


4.1. Introduction

The fourth section reports the data findings as per the research question. The initial section reports on the characteristics of the studies found in the systematic review, prevalence of alcohol consumption, drinking patterns, and alcohol use in subgroups. The section further reports on the determinants and associated risk factors of alcohol consumption, and interventions to reduce alcohol related harm in Uganda.

Figure 3: Studies included per year showing marked increase post 2016; 2 (b) heterogeneity by meta-analysis outcome — all values >85% indicate substantial heterogeneity.





4.2. Prevalence of Alcohol consumption in the Ugandan population

According to WHO (2024), current drinkers (alcohol use in the past 12 months) among those aged 15 years and above are 42.6% (52.2% for males, 33.5% for females), while daily intake was estimated to be 26.5 grams of pure alcohol. See Table 2.

On the other hand, pooled data on alcohol use prevalence for the past month indicated a lower prevalence rate of 33.7% as alcohol users, with males at 46.1% and females at 15.3% (See Table 3). These figures are not far away from the WHO (2026) hospital-based report that indicated that nearly half of screened patients were identified as being current drinkers,

4.2.1. Alcohol Per Capita Consumption (APC)

According to WHO (2025), alcohol per capita (APC) of pure alcohol in the 15+ years population was estimated to be 12.2 litres of pure alcohol and higher in males (19.9 litres) compared to 4.9 liters among females aged 15+ years. Alcohol per capita (APC) among drinkers was very high: 28.5 liters of pure alcohol (38.1 liters for males, 14.4 litres for females). However, the alcohol per capita (APC) is likely projected to decline in the coming years (2025 and 2030) to 12 liters and 9.9 litres, respectively.

Table 2: Summary statistics on alcohol consumption prevalence trends

Parameter	Male	Female	Both
Current drinkers (alcohol use in the past 12 months) in the population 15+ years	52.2%	33.5%	42.6%
Average daily intake of pure alcohol in 15+ years population	-	-	26.5 grams
Alcohol Per Capita (APC) of pure alcohol in 15+ years population	19.9 liters	4.9 liters	12.2 liters
APC among current drinkers (in liters of pure alcohol, 15+ years population)	38.1 liters	14.4 liters	28.5 liters

Source: WHO (2024) Global status report on alcohol and health and treatment of substance use disorders

Table 3: Meta-Analysis Summary — Pooled Prevalence Estimates

Outcome / Subgroup	Studies (k)	Pooled Prevalence (95% CI)	I^2 (%)
Overall alcohol use prevalence (past month), all adults	31	33.7% (28.9–38.7%)	96.2%
Males	28	46.1% (40.3–52.0%)	94.8%
Females	26	15.3% (12.4–18.6%)	93.1%

Source: Mata-Analysis

4.3. Drinking Patterns

Alcohol consumption is dominated by unrecorded alcohol and heavy use, especially among the teenage population. See Table 4

Table 4: Summary statistics on Unrecorded vs Recorded and heavy episodic alcohol consumption among the 15+ years population

Parameter	Male	Female	Both
Recorded APC of pure alcohol	-	-	6.6 liters
Unrecorded APC of pure alcohol	-	-	5.6 liters
Age-standardized Heavy Episodic Drinking (HED)	24.6%	20.7%	22%
Age-standardized HED among current drinkers	62.4%	42.6%	54.5%
Age-standardized Heavy Continuous Drinkers (HCD)	15.0%	3.5%	9.1%
Age-standardized (HCD) among current drinkers	28.7%	10.5%	21.4%

Source: WHO (2024) Global status report on alcohol and health and treatment of substance use disorders

4.3.1. Recorded vs Unrecorded Alcohol Consumption in the 15+ Years Population

According to WHO, Unrecorded APC was 5.6 litres of pure alcohol, while recorded APC was 6.6 litres of pure alcohol. On average 52-67% of alcohol consumed is unrecorded (WHO, 2024). The percentage distribution of the recorded consumption was 12.9% beer, 0.2% wine, 9.2% spirits, and 77.7% others.

4.3.2. Heavy Episodic Drinking (HED)

Both the WHO (Table 4) and pooled evidence (Table 5) indicate a similar percentage of Heavy Episodic Drinking (HED) among current drinkers. This was estimated at 54.5%, with males being higher at 62.4% compared to females estimated at 42.6%. WHO (2024) estimated Heavy Continuous Drinking (HCD) at 9.1%, but with a big difference between men and women. Male HCD was estimated at 15.0% compared to females estimated at 3.5%. The percentage of age-standardized Heavy Continuous Drinkers (HCD) among current drinkers in the 15+ years population was almost three times higher for men compared to women. The percentage for men was 28.7% compared to 10.5% for women, making an average of 21.4%.

Table 5: Pooled Prevalence Estimates on Heavy Episodic alcohol use among current drinkers

Outcome / Subgroup	Studies (k)	N	Pooled Prevalence (95% CI)	I^2 (%)
Heavy Episodic Drinking (HED) current drinkers	10	7,320	54.5% (48.1–60.8%)	88.3%

According to the UAPA Alcohol Harm Baseline Study (2026), young people, women, low-income households, and residents of urban informal settlements, fishing communities, transport corridors, and border districts face heightened vulnerability. Additionally, the UAPA baseline report revealed that although men consume more alcohol, women and girls experience disproportionate harm through gender-based violence, economic strain, caregiving burdens, and psychological trauma.

4.3.3. Age Distribution

Data from the Uganda Demographic and Health Survey (UDHS) revealed that the highest alcohol consumption was among middle-aged men. The leading age group in consuming alcohol among men was 35-39 years (47.7%), closely followed by 40-44 years (45.7%) and 45-49 years (45.5%). The trends were similar but with lower percentages among women. The leading age group in consuming alcohol among women was 40-44 years (17.3%), closely followed by 35-39 years (16.2%) and 45-49 years (16.1%). See Tables 6 and 7 below for a summary of alcohol consumption by age for men and women.

Table 6: Alcohol consumption among men aged 15-49, by age

Age	Consumed at least one alcoholic drink in the last month (%)	1-5 days (%)	6-10 days (%)	11-24 days (%)	Every day or almost every day (%)
15-19	13.1	68.7	14.0	12.4	5.0
20-24	28.2	56.3	16.9	14.3	12.6
25-29	39.9	46.2	15.5	18.6	19.8
30-34	40.3	36.7	17.8	21.4	24.1
35-39	47.7	29.6	18.0	22.8	29.6
40-44	45.7	27.7	20.4	22.8	29.1
45-49	45.5	37.9	12.9	22.8	26.4

Source: Uganda Demographic and Health Survey 2022, Tables 3.15 and 3.16.

Table 7: Alcohol consumption among women aged 15-49, by age

Age	Consumed at least one alcoholic drink in the last month (%)	1-5 days (%)	6-10 days (%)	11-24 days (%)	Every day or almost every day (%)
15-19	3.9	60.4	7.5	12.8	19.2
20-24	8.8	58.9	8.8	9.0	23.2
25-29	12.6	50.2	8.0	12.6	29.1
30-34	13.7	50.2	11.2	13.2	25.4
35-39	16.2	49.5	9.2	14.2	27.1
40-44	17.3	49.4	8.5	13.3	28.9
45-49	16.1	54.2	10.9	9.0	25.9

Source: Uganda Demographic and Health Survey 2022, Tables 3.15 and 3.16.

4.3.4 Geographical Distribution of Alcohol Use in Uganda

According to UDHS (2022), Karamoja region had the highest alcohol consumption - at least one drink in the past month (men:71.7% and women:62.4%), followed by Kigezi region (men: 49.8%, women: 13.1%) and Ankole region (men: 44.6%, women: 8.3%). Other regions that reported high rates of alcohol consumption, especially among men (around 40%), included Acholi, Bunyoro, Lango, and Elgon regions. See fig 4

4.4. Alcohol Use in Subgroups

4.4.1. Teenage Alcohol Consumption (15-19 years)

Teenage alcohol consumption is lower than the general consumption but characterized by Heavy Episodic Drinking (HED). According to WHO (2024), teenage alcohol use was 22.6% (24.6% for males, 20.7% for females). See Table 9. However, pooled studies indicate a higher prevalence of alcohol use of 29.4% in the subgroup of 15-24 years. See Table 10 below.

The percentage of HED among current drinkers in the 15-19 years population was 59.7%. The percentage of HED in this population was higher for men (15.2%) than for women (11.6%). The average percentage of HCD in the 15-19-year population was 3.5% (5.3% for men, more than double that of women at 1.7%). The percentage of Heavy Continuous Drinkers (HCD) among current drinkers in the 15- 19-year population was more than triple for men compared to women. The percentage for men was 21.6% compared to 8.3% for women, making an average of 15.5%.

Table 8: Alcohol consumption among those aged 15–19 years– Adopted from the WHO Global Status Report 2024

Parameter	Male	Female	Both
Current drinkers in the 15-19 years population	24.6%	20.7%	22.6%
HED in the 15- 19 years population.	15.2%	11.6%	13.5%
HED among current drinkers in the 15- 19-year population.	61.8%	55.8%	59.7%
HCD in the population aged 15–19 years.	5.3%	1.7%	3.5%
Percentage of heavy continuous drinkers (HCD) among current drinkers in the 15- 19-year population.	21.6%	8.3%	15.5%

Adopted from WHO Global Status Report 2024

Table 9: Meta-analysis Summary — Pooled Prevalence Estimates of alcohol consumption among young people aged 15-24 years

Outcome / Subgroup	Studies (k)	N	Pooled Prevalence (95% CI)	I^2 (%)
Youth (15–24 years)	12	8,650	29.4% (23.1–36.4%)	92.5%

4.4.2. Comparing Alcohol Use in Rural and Urban Areas

Urban settings (38.4%) had an edge in alcohol use compared to rural settings (35.1%) (Table 10). Alcohol consumption however was higher in men living in rural areas (35.5%) compared to those living in urban areas (27.9%). Although the percentages are much lower among women, the UDHS 2022 revealed that rural women (11.7%) consumed slightly more alcohol than urban women (10.4%). See table 11

Table 10: Meta-Analysis Summary — Pooled Prevalence Estimates among subgroups

Outcome / Subgroup	Studies (k)	N	Pooled Prevalence (95% CI)	I^2 (%)
Urban settings	18	21,500	38.4% (31.8–45.3%)	95.4%
Rural settings	16	28,740	35.1% (28.6–42.1%)	94.9%
Fishing communities	7	4,210	52.6% (43.1–62.0%)	91.2%
PLHIV subgroup	14	9,880	40.2% (33.6–47.1%)	93.7%
Alcohol use in pregnancy	4	2,210	30.8% (18.4–45.7%)	96.8%

Table 11: Consumed at least one alcoholic drink in the last month (%) for Women and Men

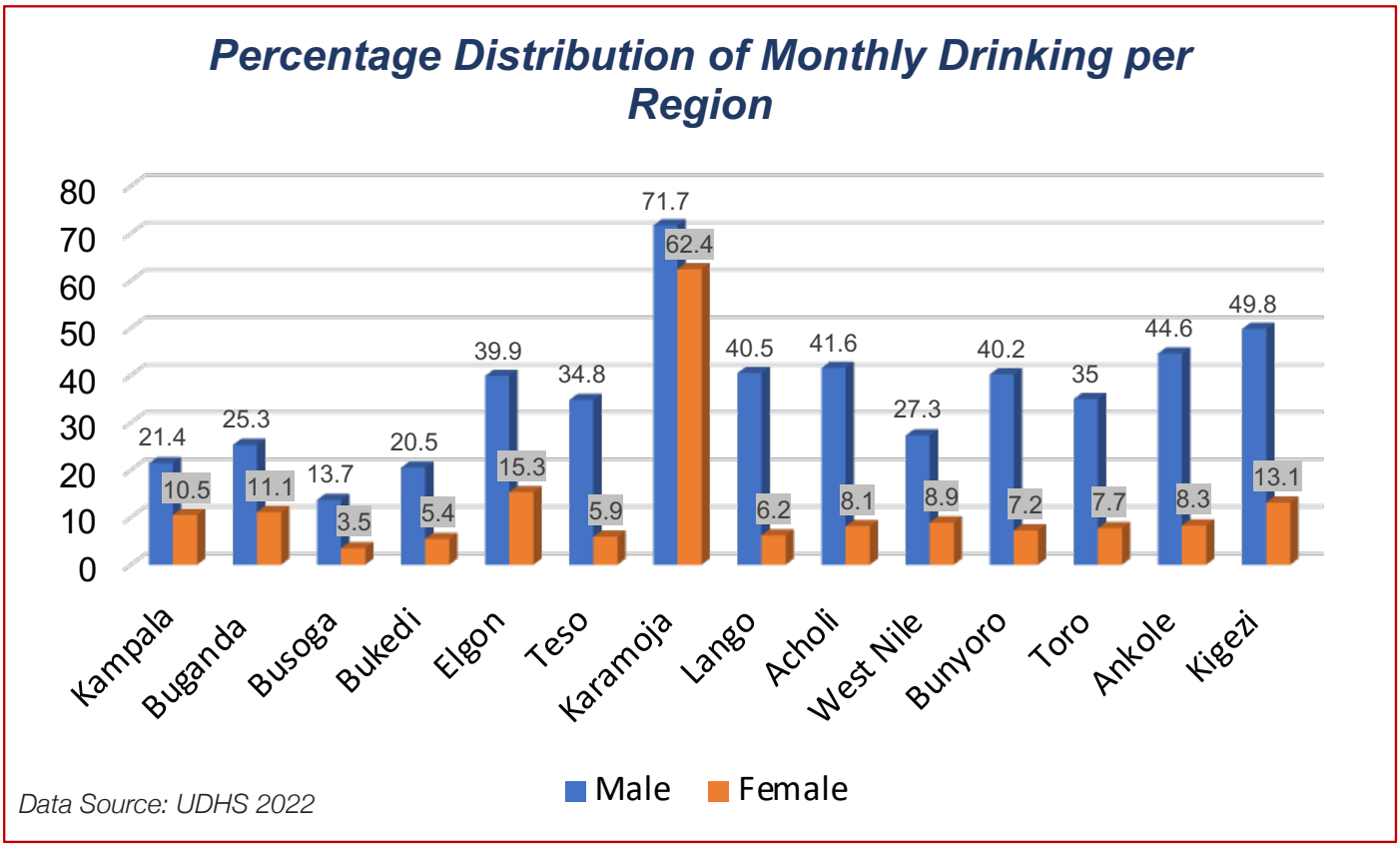
Residence	Consumed at least one alcoholic drink in the last month (%) – Women	Consumed at least one alcoholic drink in the last month (%) – Men
Urban	10.4	27.9
Rural	11.7	35.5

Data Source: UDHS 2022

4.4.4. Geographical Distribution of Alcohol Use in Uganda

UDHS 2022 reported a higher frequency of daily drinking among women than men in some regions - According to UDHS (2022), Karamoja region had the highest alcohol consumption - at least one drink in the past month (men:71.7% and women:62.4%), followed by Kigezi region (men: 49.8%, women: 13.1%) and Ankole region (men: 44.6%, women: 8.3%). Other regions that reported high rates of alcohol consumption, especially among men (around 40%), included Acholi, Bunyoro, Lango, and Elgon regions. See figure 4.

Figure 4: Percentage Distribution of Monthly Drinking per Region



Data Source: UDHS 2022

Conversely, it is important to note that in some cases, UDHS 2022 reported a consumption of alcohol among women than men. For instance, in Karamoja, Lango, Teso, Ankole, and Kigezi regions, more women reported daily drinking. In Karamoja region, up to 56.3% of women surveyed reported having taken alcohol daily/almost daily compared to 21.4% of men. Similarly, in the Lango region, 28.3% of women surveyed took one alcoholic drink daily/almost daily compared to 19.7% of men. It was similar in the Teso region, with 26.1% of women compared to 18.7% of men who reported taking at least one alcoholic drink daily/almost daily. Similar occurrences were in the Ankole region, with 15.4% of women compared to only 7.1% of men, and in the Kigezi region with 20.5% of women compared to 17.5% of men, who reported taking at least one alcoholic drink daily/almost daily. It should also be noted, however, that the number of women and men who responded per region differ substantially. See Table 12.

Table 12: Comparison of men and women who drank alcohol daily per region

Region	Consumed at least one alcoholic drink in the last month (%) - Women	Consumed at least one alcoholic drink in the last month (%) - Men	Number of respondents - Women	Number of respondents - Men	Every day or almost every day (%) – Women	Every day or almost every day (%) - Men
Kampala	10.5	21.4	944	242	15.8	24.5
Buganda	11.1	25.3	4,470	1,197	10.7	22.0
Busoga	3.5	13.7	1,631	421	26.7	29.4
Bukedi	5.4	20.5	945	264	13.7	23.5
Elgon	15.3	39.9	867	281	21.3	27.7
Teso	5.9	34.8	1,256	402	26.1	18.7
Karamoja	62.4	71.7	895	172	56.3	21.4
Lango	6.2	40.5	1,219	359	28.3	19.7
Acholi	8.1	41.6	761	222	4.9	17.9
West Nile	8.9	27.3	734	192	7.3	14.4
Bunyoro	7.2	40.2	1,170	314	16.9	53.9
Toro	7.7	35.0	1,307	379	6.6	11.6
Ankole	8.3	44.6	1,322	410	15.4	7.1
Kigezi	13.1	49.8	731	175	20.5	17.5

Source: Uganda Demographic and Health Survey 2022, Tables 3.15 and 3.16.

4.4.5. Alcohol Consumption by Socioeconomic Status

The UDHS 2022 further revealed that both men and women in the lowest wealth quintile consumed more alcohol than (at least one drink in the last month and daily drinking) those in the second, middle, fourth and highest wealth quintiles. See Tables 12 and 13. On the contrary, it is important to note that more women in the lowest wealth quintile, accounting for 44.4% compared to 26.5% for men, reported consuming at least one alcoholic drink daily/almost daily. There seems to be a negative correlation between alcohol consumption and income, with this more pronounced among women.

Table 13: Alcohol consumption among men aged 15-49, by wealth quintile

Wealth Quintile	Consumed at least one alcoholic drink in the last month (%)	1-5 days (%)	6-10 days (%)	11-24 days (%)	Every day or almost every day (%)
Lowest	40.5	38.2	15.3	20.0	26.5
Second	39.7	43.9	14.5	20.7	20.9
Middle	35.6	41.7	19.7	16.8	21.7
Fourth	29.0	39.7	17.2	19.5	23.6
Highest	24.4	48.8	16.2	20.8	14.2

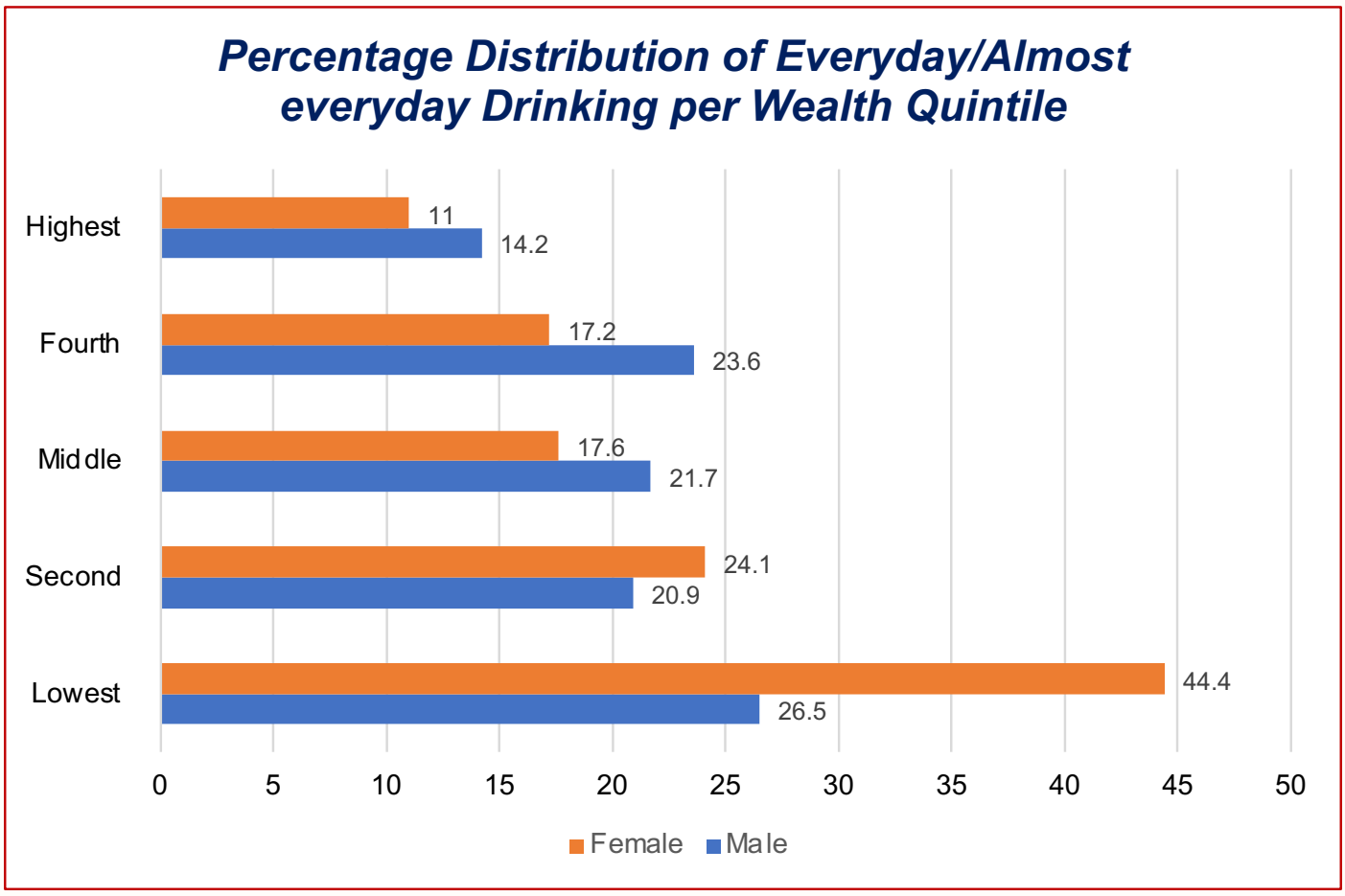
Source: Uganda Demographic and Health Survey 2022, Tables 3.15 and 3.16.

Table 14: Alcohol consumption among women aged 15-49, by wealth quintile

Wealth Quintile	Consumed at least one alcoholic drink in the last month (%)	1-5 days (%)	6-10 days (%)	11-24 days (%)	Every day or almost every day (%)
Lowest	20.9	23.4	8.9	23.3	44.4
Second	9.7	57.7	10.5	7.7	24.1
Middle	7.6	67.0	8.5	6.9	17.6
Fourth	9.1	65.6	10.6	6.6	17.2
Highest	9.9	75.6	8.0	5.4	11.0

Source: Uganda Demographic and Health Survey 2022, Tables 3.15 and 3.16.

Figure 5: Percentage Distribution of Everyday/Almost Everyday Drinking per Wealth Quintile



Data Source: UDHS 2022

4.4.6. Alcohol Use and Education

Data from UDHS reveals a negative correlation between higher education and alcohol consumption in both men and women (Tables 14 and 15). The data show that more women than men with no education took at least one alcoholic drink daily/almost daily. Only 20.4% of men with no education consumed alcohol on a daily/almost daily basis, yet for women with no education it was 45.5%, accounting for more than double the number of men who reported taking at least one alcoholic drink daily/almost daily. The data revealed that the rate of alcohol consumption on a daily/almost daily basis decreased with an increase in level of education for women, but instead consumption increased for men. The data showed that up to 20.4% of men with no education reported taking an alcoholic drink daily/almost daily compared to 22.3% of the men with education beyond secondary level, who reported taking a drink daily/almost daily. For women, the percentage reduced from 45.5% for women with no education to 11.0% for women with education above secondary level who reported taking one alcoholic drink daily/almost daily.

Table 15: Alcohol consumption among men aged 15-49, by education

Education	Consumed at least one alcoholic drink in the last month (%)	1-5 days (%)	6-10 days (%)	11-24 days (%)	Every day or almost every day (%)
No education	52.1	33.2	24.7	21.7	20.4
Primary	34.0	42.1	15.5	20.5	21.9
Secondary	29.0	43.1	18.8	17.8	20.2
More than secondary	30.9	47.7	13.4	16.6	22.3

Source: Uganda Demographic and Health Survey 2022, Tables 3.15 and 3.16.

Table 16: Alcohol consumption among women aged 15-49, by education

Education	Consumed at least one alcoholic drink in the last month (%)	1-5 days (%)	6-10 days (%)	11-24 days (%)	Every day or almost every day (%)
No education	32.3	18.3	9.0	27.2	45.5
Primary	10.0	60.7	10.3	7.6	21.4
Secondary	7.6	74.0	5.6	4.7	15.7
More than secondary	8.9	68.2	13.3	7.4	11.0

Source: Uganda Demographic and Health Survey 2022, Tables 3.15 and 3.16.

4.5. Health and Social Consequences of Alcohol Consumption in Uganda

4.5.1. Alcohol Use Disorders

In Uganda, the pooled AUD prevalence based on the studies analysed was 12.4%, as summarised in Table 17 below, much higher than the global and African regional prevalence. According to the global report (WHO, 2024), the AUD prevalence globally was 7.0% (4.8% for female and 9.3% for males) and Africa region 6.3% (4.5% for females and 8.3% for males).

Table 17: Meta-Analysis Summary — Pooled Prevalence Estimates of Alcohol Use Disorder

Outcome / Subgroup	Studies (k)	N	Pooled Prevalence (95% CI)	I^2 (%)
Alcohol use disorder (AUD) prevalence	8	5,640	12.4% (8.9–16.6%)	89.6%

4.5.2. Alcohol Attributable Deaths (AAD), Alcohol Attributable Fractions (AAF)

Alcohol Attributable Deaths (AAD) are the total fatalities in a given population that would not have occurred if alcohol consumption had been removed. The number of AAD from all causes and all ages was 17,065 (13,684 for men and 3,382 for women) (see Table 17).

Alcohol Attributable Fractions (AAF) are deaths where alcohol is a major contributing factor or known risk factor, such as road traffic crashes, homicides, suicides, and certain types of cancer (like breast, liver, or esophageal cancer. The percentage of Alcohol Attributable Fractions (AAF) for deaths from all causes was higher for men at 10.6% for males, 3.4% for females, and 7.5% for both. The Alcohol Attributable (AA) deaths per 100,000 population from all causes and all ages were in tandem with the AA deaths.

Table 18: Summary statistics on alcohol harm

Parameter	Male	Female	Both
Percentage of AAF for deaths from all causes in the 15+ years population.	10.6%	3.4%	7.5%
Number of Alcohol Attributable (AA) deaths from all causes and all ages.	13,684	3,382	17,065
Alcohol Attributable (AA) deaths per 100,000 population from all causes and all ages.	156.0	32.8	86.6
Percentage of alcohol Attributable Fractions (AAF) for Disability Adjusted Life Years (DALYs) lost (2019) from all causes.	7.6%	2.3%	5.2%
Number of Alcohol Attributable DALYs lost (2019) from all causes.	696,493	177,310	873,804
Alcohol Attributable DALYs lost per 100,000 population.	5,734.4	1,221.5	3,300.0

Source: WHO (2024) Global status report on alcohol and health and treatment of substance use disorders

4.5.3. Disability-Adjusted Life Years (DALYs) Lost

The percentage of alcohol Attributable Fractions (AAFs) for disability-adjusted life years (DALYs) lost (2019) from all causes was 7.6% for men and 2.3% for women, making an average of 5.2% (Table 17). The number of Alcohol Attributable DALYs lost (2019) from all causes was more than triple for men compared to women. The number of alcohol attributable DALYs lost for men was 699,493, 177,310 for women, and 873,804 combined. The Alcohol Attributable DALYs lost per 100,000 population was more than triple for men compared to women. The alcohol attributable DALYs lost per 100,000 population was 5,734.4 for men and 1,221.5 for women, making an average of 3,300.

4.5.4. Alcohol and Road Accidents

In Uganda, driving under the influence of alcohol has always been one of the causes of road traffic accidents over the years. According to the Uganda Police Annual Crime Report (2023), driving under the influence of alcohol was responsible for up to one thousand (1,000) offences reported, although these reduced considerably to 227 in 2024 (UPF, 2024). It's important to note that not all traffic incidents resulting into deaths and injuries may be reported and reported.

In addition to traffic road accidents, alcohol harm extends beyond individual heath to occupational accidents, mental health distress, crime, and productivity losses. Furthermore, alcohol-related absenteeism, presenteeism and injuries reduce household welfare and national economic output. Also, alcohol-related harm puts pressure on health justice and social protection systems. (UAPA Alcohol Harm Baseline Study, 2026).

4.5.6. Other Social, and Economic Consequences of Harmful Use of Alcohol in Uganda.

40%

Highlighted social isolation and unemployment status as a reason for consuming alcohol.

Harmful use of alcohol is responsible for several health, social, and economic consequences. The patriarchal nature of most communities makes men's harmful drinking acceptable while women and children disproportionately experience its consequences, including gender-based violence, economic strain, and psychosocial stress (Swahn et al., 2020; UBOS, 2023). In their survey on factors associated with the prevalence of alcohol consumption in Lira City West, northern Uganda, Isabirye I. et al. (2024) revealed that, socioeconomically, 40% highlighted social isolation and unemployment status as a reason for consuming alcohol, while 30% attributed drinking to chronic illnesses.

Gender based violence: Isabirye and colleagues reported that 50% of alcohol consumption situations culminated in violence and aggressive behavior. Socially, evidence from urban informal settlements further shows that men's drinking heightens risks of intimate partner violence and household instability, while women's limited agency restricts their ability to seek safety or support (Kasirye et al., 2018; Devries et al., 2014). Relatedly, and in line with the findings of this study, it was revealed that girls experience higher levels of alcohol related risky

sexual behavior (57.9%) compared to boys (41.9%) (Swahn et al., 2020). Besides, national data from different sources concur with and further validate the study findings on the consequences of harmful use of alcohol.

The annual report of the Uganda Police Force (2023) highlighted that alcohol is a major contributing factor in domestic violence, defilement, and sexual offences in annual crime reports (UPF, 2023). Similarly, within the Justice, Law and Order Sector (JLOS), gender-based violence (GBV) cases remain among the most reported offences, with alcohol frequently cited as a catalyst in both perpetration and victim vulnerability. Additionally, data from the Uganda Demographic and Household Survey Report (2022) show that women disproportionately experience GBV, with over 56% of ever-married women reporting physical or sexual violence in their lifetime. The Ministry of Gender, Labor and Social Development (MGLSD) report (2020) highlighted that alcohol misuse contributes to household instability, economic deprivation, and intergenerational cycles of violence.

Health sector data from UNFPA indicates that alcohol use is closely linked to risky sexual behavior, unintended pregnancies, and increased HIV risk among adolescent girls and young women (UNFPA, 2021). Evidence from the Ministry of Health (MoH) further shows that alcohol-related harm disproportionately affects women through injuries, mental health conditions, and reproductive health risks (MoH, 2019).

4.6. Determinants and Associated Risk Factors of Alcohol Consumption in Uganda.

Alcohol marketing has been identified as a significant determinant of alcohol consumption. In their study, Heavy drinking and problem drinking among youth in Uganda: A structural equation model of alcohol marketing, advertisement perceptions and social norms, Swahn M.H. et al. (2024), highlighted that alcohol marketing exposure and allure are significant predictors of heavy drinking and problem drinking among youth in Uganda.

The marketing practices have become increasingly aggressive and predatory, yet the alcohol industry often self-regulates in terms of marketing. According to Burton and colleagues (2026), the alcohol industry has extended marketing across multiple sports, frequently linked alcohol brands to Ugandan cultural heritage and national identity, and branded across sporting activities, venues, and media reporting, positioning the industry as an important stakeholder in the sustainability of sporting and cultural activities. This works against protecting youth from marketing exposure and allure, especially since much of the alcohol marketing materials contain high violations of alcohol marketing codes (Noel et al. 2017; Swahn et al. 2024).

Besides marketing, Burton and colleagues reported Uganda to have the highest presence of alcohol industry marketing activities in selected African countries. Alcohol activities in all major sectors of society, including food, festivals and culture, environment and agriculture, health and related campaigns, Education and entrepreneurship, and road safety. These factors reinforce early initiation and harmful consumption patterns among youth, increasing vulnerability to violence and risk behaviors (Monica H. Swahn et al., 2020; WHO, 2022), contributing to sustained widespread consumption and eventually alcohol harm.
Similarly, alcohol consumption is driven by entrenched factors such as peer pressure, affordability, and using alcohol to cope with hardship. Niwagaba K. et al., (2025) revealed that illicit alcohol drinkers showed a higher prevalence of recent illicit alcohol consumption among low-income, less-educated male youths.

60%

Reported community tolerance in public places as a trigger.

6-13

Age range of primary school children studied for alcohol use in Mbale district.

50%

Said school consumption always culminated in violence and aggressive behavior.

Unemployment, underemployment, and strenuous labor (such as work in bars, restaurants, or informal sectors) are strong predictors of heavy or hazardous drinking. Ziegel L. et al., (2025) further identified being male, having a low level of education, and earning a low income as key social determinants linked to alcohol use disorder (AUD) in sub-Saharan Africa.

In addition, smaller studies in rural Uganda have identified additional factors associated with AUD, such as being Christian (in contrast to the country's significant Muslim population), currently being or having been married, working as a fisherman, or as a woman employed in bars or restaurants. (Ziegel L. et al., 2025). Furthermore, lower formal education correlates with higher reliance on traditional or illicit brews, though specific urban cohorts with higher income and education can also exhibit elevated rates of social or hazardous drinking. (Ziegel L. et al. (2025).

Traditional rituals, ceremonies, and community tolerance of public drinking deeply embed alcohol into everyday social life and local livelihoods. In their survey, Isabirye I. et al. (2024) revealed that 60% of the population reported community tolerance of alcohol consumption in public places. In their study on prevalence and psycho-social factors associated with alcohol use among primary school-going children aged 6 to 13 years in Mbale district, Uganda, Nalugya et. al. (2024) revealed that several factors were associated with alcohol use among primary school-going children.

The factors included single-parent households, lower caregiver education, low socioeconomic status, maternal drinking, food insecurity, underweight, physical discipline by parents, peer influence, rural school attendance, and the school environment.

4.7 Interventions to Reduce Alcohol-Related Harm in Uganda

In their study, Organizational structure, capacity and reach of organizations involved in alcohol prevention: An assessment of stakeholders across Five Countries in East Africa, Raderalazasoa G. U. et al. (2024) revealed that the infrastructure for alcohol prevention is weak and fragmented in countries, including Uganda, where national initiatives are limited. Policy/regulatory intervention evaluation is severely underrepresented. This was evident in 5 studies included in the systematic review. Relatedly, economic analyses of the total societal cost of alcohol harm are lacking.



4.7.1. Implementation of SAFER Framework in Uganda. (The whole-of-government and whole-of-society approach to preventing alcohol harm)

Uganda was the first country to adopt SAFER as a national delivery platform to prevent alcohol harm. By the end of 2025, an estimated 1139 key stakeholders – including policymakers, health workers, and local leaders – were actively engaged through SAFER implementation processes in 2025.

In October 2025, the Office of the Prime Minister convened the first multisectoral meeting in Kampala, bringing together government agencies to discuss alcohol policy measures (WHO 2026). Participants in the multisectoral meetings include the Ministry of Health, the National Drug Authority, the Uganda Heart Institute, the Uganda Lung Institute, the Uganda Revenue Authority (URA), the National Mental Referral Hospital, the Ministry of Internal Affairs, the Office of the President, State House, the Uganda Cancer Institute, the Uganda National Bureau of Standards, the Ministry of Education and Sports, civil society (Uganda Alcohol Policy Alliance) and academia (Makerere University School of Public Health), among others.

Efforts towards Restricting Alcohol Availability

From the outset, Uganda prioritized restricting alcohol availability and strengthening health-system responses. Advocacy centred on the Alcohol Control Bill, with SAFER training for more than 100 parliamentarians and 59 local leaders to support evidence-based reforms. SAFER also mobilized cultural institutions, police and district governments, with more than 30 traditional leaders joining advocacy efforts by 2025.

Despite sustained opposition to alcohol policy measures during parliamentary debates, including

from commercial stakeholders, momentum was maintained through local bylaws, public campaigns, and the establishment of a multisectoral alcohol control committee, with parallel work initiated on a national alcohol monitoring framework and an alcohol communication strategy.

SAFER was integral in organizing the Uganda alcohol policy conferences in 2022, and 2024 brought together more than 500 participants and positioned SAFER Uganda as the national reference point for alcohol policy dialogue. In parallel, cross-sectoral Ugandan delegations participated in international forums such as the Global Alcohol Policy Conference and the WHO Forum on Alcohol, Drugs and Addictive Behaviors. These exchanges not only raised Uganda's international profile but also reinforced domestic collaboration across ministries, civil society and academia.

Integrating the SBIRT program in the Health-System Integration

Uganda integrated Screening, Brief Intervention,
and Referral to Treatment (SBIRT) into primary health-care services. A national SBIRT working group developed a tailored protocol, training tools, and information, education, and communication materials. Pilot programmes in Jinja and Kampala districts trained more than 60 health workers and officials. In 2025, the Ministry of Health technical committees approved piloting the SBIRT protocol in two health facilities, marking a major milestone towards system-wide adoption. By December 2025, SBIRT services
had reached approximately 3,435 health-service users in the two pilot centres. A reporting mechanism for SBIRT was established, and SBIRT has been incorporated into the strategic plan of the Ministry of Health. Initial results indicate a substantial shift in detection of and response to alcohol use (WHO, 2026)

Fiscal Policy and Economic Evidence

Building on parliamentary debates on excise reforms, SAFER Uganda and partners contributed to amendments to the Excise Duty Acts (2024 and 2025), while sustained dialogue with the Ministry of Finance, the Uganda Revenue Authority, the National Planning Authority and civil society increased the visibility of health taxation as a durable prevention instrument. In parallel, UNDP's national NCD investment case – with health-tax modelling that included alcohol information, education and communication, and locally tailored fiscal evidence used by WHO/SAFER in stakeholder sessions in May 2025- reinforced the public-health framing of excise reform and informed revenue and burden-reduction scenarios. Together, these processes helped to align alcohol taxation with Uganda's broader NCD strategy and public finance agenda, creating policy space for sustained implementation and future optimization of tax design and enforcement.

4.8 Banning of Alcohol Produced and Sold in Sachets

In 2019, Uganda introduced a ban on small high-strength alcohol sachets of 200 mL and below. A study by Burton et. al., (2026) revealed that the ban reduced temporally availability and access to the alcohol sachets and initially reduced overall consumption. However, with time, the alcohol industry replaced the sachets with plastic bottles, to which consumers switched to.

4.9 National Alcohol Policy

Uganda has several existing policy instruments, including the National Alcohol Control Policy (2019), the Narcotic Drugs and Psychotropic Substances Act (2016), and local bylaws. However, implementation

remains weak due to fragmented coordination, insufficient enforcement, alcohol industry interference, and low public awareness (UAPA, 2022; WHO, 2023). For example, there is aggressive marketing by the alcohol industry players, especially through billboards, promotions, and sponsorships of popular events and sports games. This has increasingly shaped and intensified alcohol consumption behavior among the general population with little or no policy intervention to deter the escalation due to the challenges highlighted above.

4.10 Alcohol Control Bill

The 2023 Alcoholic Drinks Control Bill was developed, and efforts were made to have it tabled for hearing and ratification. However, it was rejected following industry lobbying and inadequate political support. The gap remains evident and needs to be filled to address the unregulated consumption of alcohol.

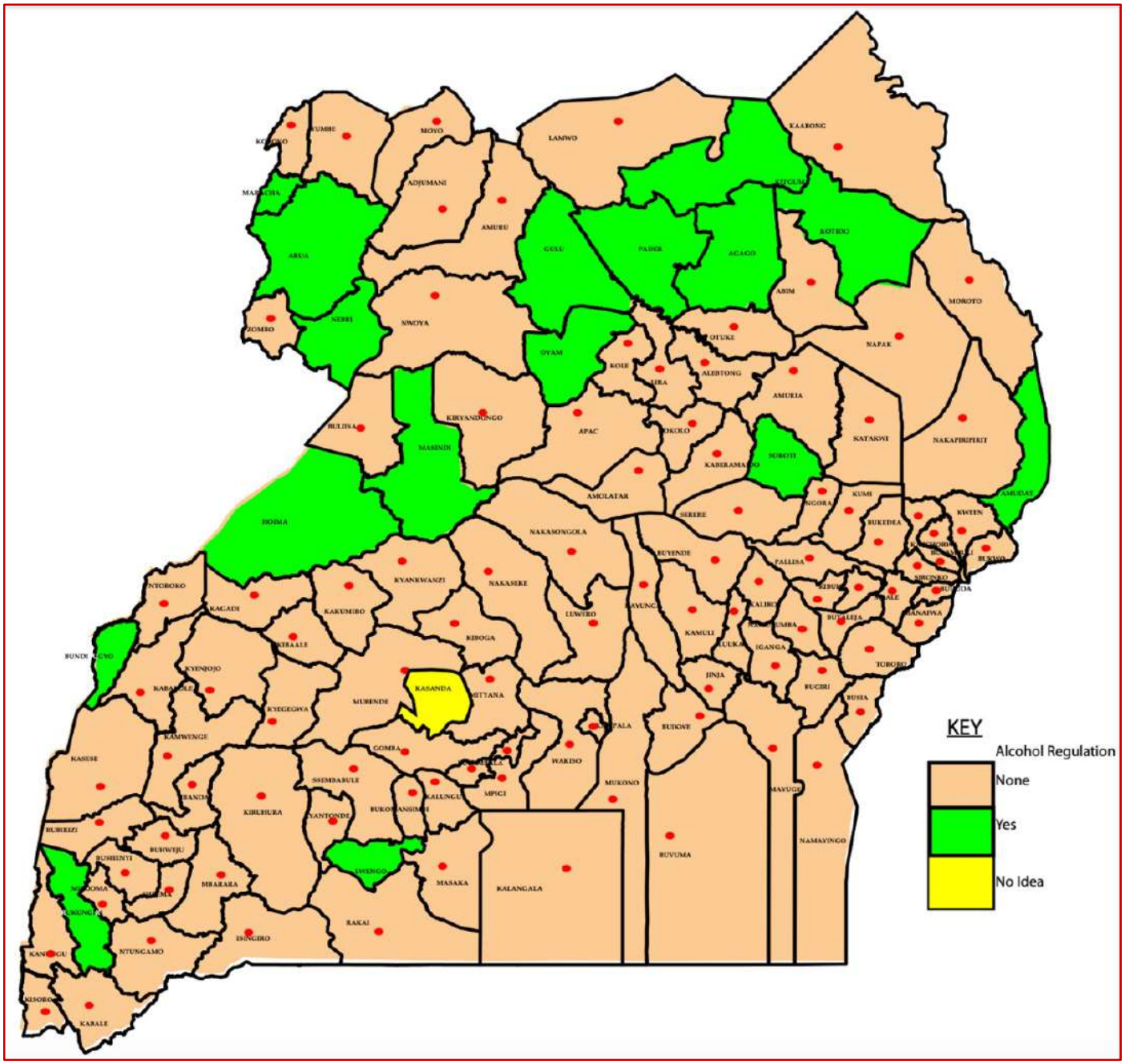


4.11 Local Alcohol Regulation

Findings from the grey literature reviews were in tandem with the systematic literature review results. In Uganda, there are varied levels of policy regulation and enforcement across the country. Only 14.6% of districts had any alcohol regulation in place (Kikome et al., 2023). The report on the availability of alcohol regulation in the 137 districts of Uganda showed that only 20 districts (14.6%) had alcohol regulations. Up to 116 districts (84.7%) did not have any regulation, while the respondent from one district (0.7%) did not know whether the district indeed had a regulation or not (Kikome et al., 2023). The map below shows the distribution of alcohol regulation across Uganda.

The map below shows the distribution of alcohol regulation across Uganda.

Figure 6: Distribution of Alcohol Regulation in Uganda – adopted from the Report on the Availability of Alcohol Regulation in the 137 districts of Uganda.



4.12 Treatment for Alcohol Use Disorders

Treatment of Alcohol Use Disorders (AUDs) remains a challenge. There are critical gaps in access to quality and ethical treatment for substance use disorders. This is because treatment of AUDs is largely limited and unaffordable for those who need it the most. Uganda is working on national guidelines or standards for treatment and care for public specialized treatment services. According to Kalema D. et al. (2017), in their paper on treatment challenges, it was revealed that there are institutional, societal, and individual challenges. Institutional challenges included inadequate human resources, overall insufficiency of services, and the treatment philosophy of available services. Stigma and cultural interference were identified as challenges at the societal level, whereas limited awareness about addiction and denial of such problems were identified at the individual level. In their study, "several respondents stated that many persons with AUD do not know that alcoholism is a treatable disorder" Kalema D. et al., 2017).

5 The Burden of Alcohol Consumption in Uganda: Insights and Policy Implications for Harm Prevention



According to the WHO Global Investment case for Noncommunicable Diseases report (2025), investing in alcohol policy delivers economic returns. The report asserts that for every US$1 invested in alcohol policies, countries can expect an estimated return of between US$8.00 and US$9.00 through the implementation of the WHO best buys. Such returns would come in the form of reduced health care costs, increased workforce productivity, lower costs related to crime and injuries, and reduced burden on social services, among others.

5.1. Prioritize Policies for Preventing Alcohol Harm in Uganda

Findings of the 2026 Alcohol Status Report highlight several priorities that could be pivotal in the fight against alcohol harm. Identified data support strategies that target the pattern, not just the pint, tackle heavy episodic and informal drinking behaviors, prioritize alcohol prevention for high-risk groups, address the rising alcohol consumption among women, build momentum for the declining trends of alcohol use, and protect alcohol policy from the undue influence of the alcohol industry.

5.1.1. Targeting the Pattern, Not Just the Pint: Tackling Heavy Episodic and Informal Drinking Behaviors

For over two decades, Uganda has been dominated by high alcohol consumption, most of which is unrecorded. Pooled data from our literature review and the latest WHO report indicate alcohol use prevalence for people in Uganda to be around 34%, which is comparatively higher than the global and African region average consumption of 7% and 6.3%, respectively.



12.2 litres

Uganda's annual alcohol consumption reaches 12.2 litres per adult, exceeding twice the African regional and global averages.

70%+

Unrecorded, artisanal or illicit drinks of Uganda's total 170 million-litre alcohol market (Niwagaba K. et al., 2025).

34%

Alcohol use prevalence in Uganda according to pooled data from literature review and the latest WHO report.

Uganda's alcohol per capita (APC) of 12.2 litres of pure alcohol per year among adults aged 15 years and older is more than twice the WHO African Region average and doubles the global average (WHO AFRO, 2023). This rate is far above the current global average consumption of 27 grams per day among drinkers and makes the country the highest alcohol consuming country in Africa and fifth globally. The finding that over half of current drinkers engage in Heavy Episodic Drinking is particularly a great concern and calls for interventions to reduce alcohol consumption among drinkers.

Equally concerning is the highest proportion of informal alcohol consumption. While WHO estimates that informal alcohol is almost half of the alcohol sector, some researchers such as Niwagaba K. et al. (2025) report an even higher percentage (Over 70%) of unrecorded, artisanal, or illicit drinks on the Ugandan alcohol market. The coexistence of formal and informal alcohol markets undermines licensing, taxation, and age-based restrictions. On average, informal alcohol is largely unregulated (WHO, 2024), yet formal alcohol heavily relies on self-regulation by the alcohol industry. This poses significant risks due to inconsistent strength, unsafe production, and potential contamination. Reducing the informal sector will increase government revenue while protecting Ugandans' health.

30.8%

of pregnant women consume alcohol according to pooled data.

14.6%

of Uganda's 137 districts have any operational alcohol regulation in place.

2019

National Alcohol Control Policy formulated in 2019 to guide action across relevant stakeholders.

2023

Alcohol Drinks Control Bill (2023) rejected by parliament in August 2024 following joint committee review.

5.1.2. Prioritizing Alcohol Prevention for High-risk Groups: Young People, Men, Fishing Communities and PLWH/A

According to the UDHS (2022), alcohol consumption rises steadily with age, with the sharpest increase occurring between ages 16-24 years. Data further indicate higher consumption among males across all ages. Men contribute up to 75% of alcohol consumption in Uganda, with those in rural areas consuming more alcohol than their counterparts in urban areas. Fishing communities and PLWH/A are also reported to have higher-than-average alcohol consumption prevalence. According to UDHS (2022), Karamoja region had the highest alcohol consumption, followed by Kigezi region and Ankole region.

This finding underscores the magnitude of the public health challenge in the cited populations. For instance, the number of Alcohol Attributable (AA) deaths is more than triple for men compared to women. Maritime reviews in this study reported that 61% of alcohol-consuming fishers were involved in workplace or boat-related accidents.

Alcohol use among people living with HIV/AIDS (PLWH/A) is also concerning, considering the cyclical relationship of the two conditions and its harmful effect on the individuals and communities. Intoxication impairs risk perception and lowers inhibitions, correlating heavily with condomless sex, transactional sex, and disproportionately higher rates of HIV/STI transmission in fishing hubs (such as around Lake Victoria). Further to that, studies in small-scale fisheries (e.g., in South Asia and parts of Africa) link high rates of male alcoholism to elevated domestic violence and severe economic strain on women and households.

Harm in the high-risk groups and calls for further research and evidence-based interventions for alcohol harm prevention in the mentioned communities. Thakarar. K. et. al. (2017) suggests that alcohol harm control for PLWH/A in Uganda combines clinical interventions, national policy frameworks, and community-driven strategies.

5.1.3. Address the rising Alcohol Consumption among Women

While WHO and pooled statistics indicate a lower rate of alcohol use among women compared to men, in Uganda, some population specific study warrants attention to particular women subgroups, such as those living in Karamoja, the low social economic background and pregnant mothers. Women in Karamoja consume more alcohol



than men in all other regions except Karamoja. The UDHS (2022) revealed that women in the lower wealth quintile and those with lower academic attainment consumed more alcohol and engaged in more daily drinking than men. Pooled data indicated that 30.8% of pregnant women consume alcohol.

Studies document a concerning increase in alcohol use among Ugandan women, raising worries about associated health risks and adverse effects across key developmental phases. Women in Uganda are increasingly consuming alcohol due to aggressive and unregulated marketing, social and economic stressors, and a high availability of cheap, unrecorded spirits (MOH, 2022). A society dominated by widespread consumption of alcohol among women has several challenges. High consumption of alcohol among women is associated with elevated cancer risks, accelerated organ damage, reproductive and hormonal disruptions, among other challenges (White A., et. al., 2015).

5.1.4. Protect Alcohol Policy from the Undue Influence of the Alcohol Industry

In some instances, policy implementation has been ineffective due to Machiavellian ingenuity used by the alcohol industry to use strategic manipulation and avoid the requirements of some policy requirements. For example, in 2019, Uganda implemented a strict national ban on the production and sale of alcohol packaged in sachets, setting a minimum volume limit of 200ml and requiring a complete shift to plastic or glass bottles. Spearheaded by the Ministry of Trade, Industry and Cooperatives, the policy aimed to curb rampant underage drinking, public health hazards, and environmental litter (MoH, 2019; MTIC, 2019; Kasirye et al., 2024). However, producers quickly used crafty ingenuity and started using small bottles and other low-volume containers that maintained easy access, affordability, and convenience.

Most recently, the alcohol industry openly rejected the alcohol law and successfully fought against its enactment. Button reports that such incidents are not only in Uganda and cites South Africa, where similar situations of sabotaging alcohol regulation have occurred. Stakeholders must therefore call upon government to protect alcohol policy from commercial influence by strengthening conflict of interest safeguards, improving transparency, and limiting the alcohol industry's involvement in policy development.



6.3L → 4.8L

Total APC declined from 6.3 litres in 2016 to 4.8 litres in 2019 in the WHO African region.



12.2L

Uganda's APC was estimated at 12.2L, up from 11.3L in 2020, placing it among the highest in Africa. The APC was projected to reach 12.0L in 2025 and 9.9L in 2030

5.1.5. Prevention and Treatment Options for Alcohol Use and Alcohol Use Disorders.

The UAPA baseline also highlighted that prevention interventions are still scarce, largely and informally delegated to non-state actors, the NGOs, faith-based organizations, and Community-Based Organizations (CBOs).

Treatment of Alcohol Use Disorders (AUDs) remains a challenge both globally and locally. There are critical gaps in access to quality and ethical treatment for substance use disorders. This is because treatment of AUDs is largely limited and unaffordable for those who need it the most. On the other hand While Uganda leads in alcohol use disorder, treatment efforts are still inadequate. Stigma, discrimination, and misconceptions about the efficacy of treatment contribute to the gaps in health services and low prioritization of substance use disorders by health and development agencies. Treatment of AUDs continues to be limited, especially for the vast majority who need it. According to the State of Uganda Population Report (SUPRE) 2025, it was reported specifically that the Karamoja region faces increasing cases of alcohol-related disorders but with very limited service coverage.

5.1.6. Build Momentum for the Declining Trends of Alcohol Use.

In the WHO African Region, total alcohol per capita (APC) declined from 6.3 litres in 2016 to 4.8 litres in 2019 for the 15+ years population. However, Uganda's APC was estimated at 12.2L (WHO, 2024), up from 11.3L in 2020, placing it among the highest in Africa. The APC was projected to reach 12.0L in 2025 and 9.9L in 2030. The projections, combined with Uganda's trajectory of declining alcohol attributable deaths (26.7% reduction 2010–2019), give hope to the current policy players to work harder in light of the opposing forces from the alcohol industry.

Uganda is already implementing the SAFER Framework, and with effective regulation at the National and local levels, it's possible to slow the rise in alcohol-related statistics. Yet a significant reduction in alcohol consumption and related negative consequences is unlikely to be attained without comprehensive, culturally appropriate alcohol policies, including supply reduction measures as well as sensitization, prevention, and treatment (Kalema D. et al. 2015). However, this study found that the policy framework and response are still weak and insufficient relative to the burden. Although the Ministry of Health formulated a National Alcohol Control Policy in 2019 to guide action across relevant stakeholders, it has not been comprehensively implemented. The Alcoholic Drinks Control Bill (2023), which sought to establish a legislative framework by repealing obsolete 1960s-era alcohol laws, was rejected by Parliament and only 14.6% of Uganda's 137 districts have any operational alcohol regulation in place.

The government of Uganda, through line ministries, departments and agencies, should prioritize the establishment of an effective policy and legal framework for alcohol control. The policy and legal framework should address the identified gaps in the regulation of availability, packaging, accessibility, marketing, promotion, and price of alcohol. The policy and legal framework should also be aligned with national, regional, and promising interventions like the WHO SAFER initiative that is comprehensively addressing alcohol availability, drink driving, access to screening & treatment, restrictions on alcohol advertising, marketing & promotions, and taxation & pricing policies to reduce harmful use of alcohol

The findings point to a clear need for a set of coordinated actions across policy, programming, and research. At the policy level, there is an urgent need to establish an enabling policy and legal framework, alongside strengthening regulatory measures such as minimum unit pricing, comprehensive advertising restrictions, and mandatory health warnings. This should be complemented by accelerated rollout of district-level alcohol ordinances nationwide, integration of alcohol screening and brief interventions into primary healthcare and HIV testing services, and the establishment of a robust national alcohol surveillance system embedded within the Health Management Information System (HMIS) and disaggregated by key demographic and socioeconomic indicators.

The government should also consider a multisectoral and interministerial approach through the establishment of a high-level, purpose-driven interministerial committee on alcohol control, well-funded and supported with dedicated ministerial leadership, robust success indicators, and clear accountability mechanisms. Drink-driving punitive measures, for example, should not be sporadic, isolated, and prone to corruption tendencies. Drink-driving, being a significant contributor to road traffic injuries and death, should have automatic and express punitive actions upon conviction beyond the required level of blood alcohol concentration (BAC). There is a dire need to expand random BAC breath-testing with improved coordination between Uganda Police, health facilities, and the authorities of the transport sector. Emphasis should be placed on high-risk groups in the transport sector including boda-bodas, highway passenger vehicle drivers, especially buses and taxis, and commercial vehicle drivers.

The findings point to a clear need for a set of coordinated actions across policy, programming, and research.

Working with key stakeholders like CSOs, CBOs, and development partners, local government authorities & regulatory agencies like UNBS should establish adaptive, livelihood-sensitive strategies rather than punitive enforcement alone. Controlling informal alcohol requires harmonized and simplified safety standards for traditional brews, expanding mobile testing capacity, and providing & supporting alternative livelihood options, especially for local community-based producers of alcohol who depend on brewing for their livelihood.

For development partners, priority should be placed on funding rigorous evaluations of WHO-recommended “best buy” interventions, supporting the scale-up of evidence-based behavioral interventions, and investing in national studies and prevention strategies targeting alcohol use during pregnancy, particularly in high-risk regions. Development Partners should also consider strengthening their partnership with academia and CSOs in identifying new innovative approaches to alcohol harm reduction.

Civil Society Organizations (CSOs) working towards alcohol harm reduction should strengthen collaboration among themselves and intensify effective advocacy efforts and harmonize



interventions. Short-term interventions may not effectively create the desired long-term impact, as they are unlikely to offer a wide spectrum of solutions required for effective alcohol harm reduction. CSOs must also be cognizant of and prepared to safeguard against political interference and potential conflicts of interest that may arise from the collaborations and networking.

CSOs should also embrace multi-sectoral and multi-pronged approaches, working with all the key stakeholders including but not limited to government MDAs, development partners, academia, the private sector, and the general population.

The cultural and religious leaders are in charge of enormous constituencies, and their leadership has a great influence on the people they lead. The cultural and religious leaders should consider combining efforts and support towards promising approaches & initiatives, validate regulations and restrictions established by the government agencies, and patronize enforcement measures among the communities they lead for the reduction of alcohol harm. Cultural and religious leaders should also contribute to policy formulation through policy dialogues with policymakers.

5.1.7. Reintroduce the Alcohol Law and Implementation of the Alcohol Policy

It has to be observed that the sachet ban on alcohol only provided temporary results. While results revealed that such bans reduce the availability of alcohol to young people, there is a need to extend this ban to alcohol in plastic bottles and to re-establish the alcohol control law and implement the alcohol policy. Studies reveal that alcohol sponsorships normalize alcohol consumption.



5.2. Limitations and Delimitations of the Report

This study adopted a systematic review approach combined with grey literature. This is a rigorous methodology, and it can produce robust results; however, the scientific data and studies to reference in the systematic review approach were largely scarce. This limitation explains the shallow level of comparisons between different scientific studies. Many of the reports that exist are sentimental and largely provide personal opinions and not scientific evidence. Having to explore related studies tangentially based on grey literature was not only hard but it considerably increased the time spent and cost of the exercise. It was generally hard to validate the rigor of the study as there was limited established scientific consensus. Furthermore, without objective scientific benchmarks, the subjective interpretations and unconscious biases of the researchers and reviewers are more likely to influence the conclusion of the study.

Relatedly, some of the scientific papers also have shallow analysis that might leave a lot to be desired. Without strong scientific studies to compare findings against, assessing the validity, reliability, and accuracy of your results becomes highly subjective and difficult. Very high I^2 values (88–97%) limit interpretability of pooled estimates. Publication bias, while not statistically detected, cannot be fully excluded. Overrepresentation of studies among PLHIV (45%) limits generalizability to the broader population. Most studies relied on self-reported alcohol use. Biomarker validation (PEth) was used in a minority of studies. Inconsistent use of validated screening instruments limits cross-study comparability.

Grey literature also has specific limitations,

including a lack of peer review. Most grey literature bypasses formal academic or editorial peer review, raising questions about scientific validity, accuracy, and potential hidden bias. Grey literature is also hard to find and index. Unlike journal articles housed in standardized databases (like PubMed or Scopus), grey literature is scattered across individual agency, NGO, or corporate websites and is rarely indexed uniformly. In addition, it is important to note that editing standards for grey literature are often less stringent, and documents frequently lack crucial methodological details, structured abstracts, or complete bibliographic data.

In view of the limitations, several mitigations were put in place to address them. Critical among the strategies that were considered was the Expert Team that was set up to provide expert reviews,
input and guidance to the development of this report. The Expert Team developed the methodology and provided expert guidance throughout the process and ensured that relevant insights are integrated in this report to adequately inform policy and advocacy work in the area of alcohol harm prevention. The report was also subjected to a wide and rigorous validation process involving multiple stakeholders who provided invaluable input to this report. The validation process was very critical for checking the integrity, completeness, accuracy, and relevancy of the report. In addition, the validation process also facilitated the building of confidence and ownership of the report among partners, and regulators alike.

Furthermore, the process of developing this report considered a wide range of sources of information including sources from diverse contexts. This diversity of sources provided perspectives and data from multiple contexts rather than a single perspective. Studies from other countries helped in achieving clarity, accuracy and providing sound judgement. Subsequently, this report provides strong basis for policy and advocacy work for the reduction of alcohol harm in Uganda.

5.3 Conclusion

Alcohol consumption in Uganda is highly prevalent, deeply embedded in social and economic contexts, and associated with a broad spectrum of health and social harms. Uganda's trajectory of declining alcohol use and related deaths demonstrates that progress is possible but requires consistent and strong political will, adequate resourcing, and multisectoral action. In addition, meaningful progress requires effective and comprehensive legislation, sustained investment in evidence-based interventions, strengthened human capital, and inclusive social and economic development, with emphasis on vulnerable populations.

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