World Health Organization

POLICY RESPONSE TO ALCOHOL CONSUMPTION AND TOBACCO USE DURING THE COVID-19 PANDEMIC IN THE WHO SOUTH-EAST ASIA REGION

PREPAREDNESS FOR FUTURE PANDEMIC EVENTS

BRIEF ❼, JULY 2022

SNAPSHOT SERIES ON ALCOHOL CONTROL POLICIES AND PRACTICE

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ABOUT THE SERIES

In 2022 – more than a decade after adopting the WHO global strategy to reduce the harmful use of alcohol – attention has been called to accelerate the implementation of high-impact interventions for alcohol control. Recent efforts including the global action plan for 2022–2030 aim to leverage the available evidence and policy know-how and quicken progress in tackling alcohol consumption and its effects. Making evidence accessible and spotlighting real-world experiences is a core component for advancing the implementation of effective policy interventions. Doing so requires a multipronged approach that addresses the social and cultural acceptability of alcohol consumption, its availability and affordability.

In 2021, WHO launched a series of advocacy briefs about "blind spots" related to reducing alcohol consumption. The resulting topic-specific briefs were considered starting points for navigating the evidence and its use in practice, forming the first edition of the "Snapshot Series". Topics covered in 2021 included socioeconomic inequalities, unrecorded alcohol consumption, conflicts of interest, labelling, digital marketing and per capita alcohol consumption.

Now in its second edition, this series continues its aim to create topical "snapshots", serving as a compass for navigating critical issues related to the high-impact and innovative interventions to accelerate progress in reducing alcohol consumption.

This second edition of the series provides a portfolio of policy guidance tackling the determinants driving the acceptability, availability and affordability of alcohol. It explores, among other topics, alcohol outlet licensing, location and density, alcogenic settings and adolescents, gender-responsive alcohol control policies, zero- and low-alcohol beverages.

How was this brief developed?

The 2022 series has evolved in its approach to best meet the information needs of its readership, applying a four-step process to explore each topic. First, leading experts were engaged in searching and consolidating the available scientific evidence. Second, the first-hand experiences of countries related to the topic were sampled and documented. Third, stakeholders were brought together in webinars to discuss the evidence and country experiences. Lastly, the literature, experiences from countries and insights from discussions were brought together in a brief report that forms the varied issues of the "snapshots".

Audience

The series is intended for a broad audience, including people working in public health, and local and national alcohol and tobacco policy; policy-makers from national, regional and local administrations; government officials; researchers; civil society groups; consumer associations; the mass media; and people new to alcohol control policy, research or practice.

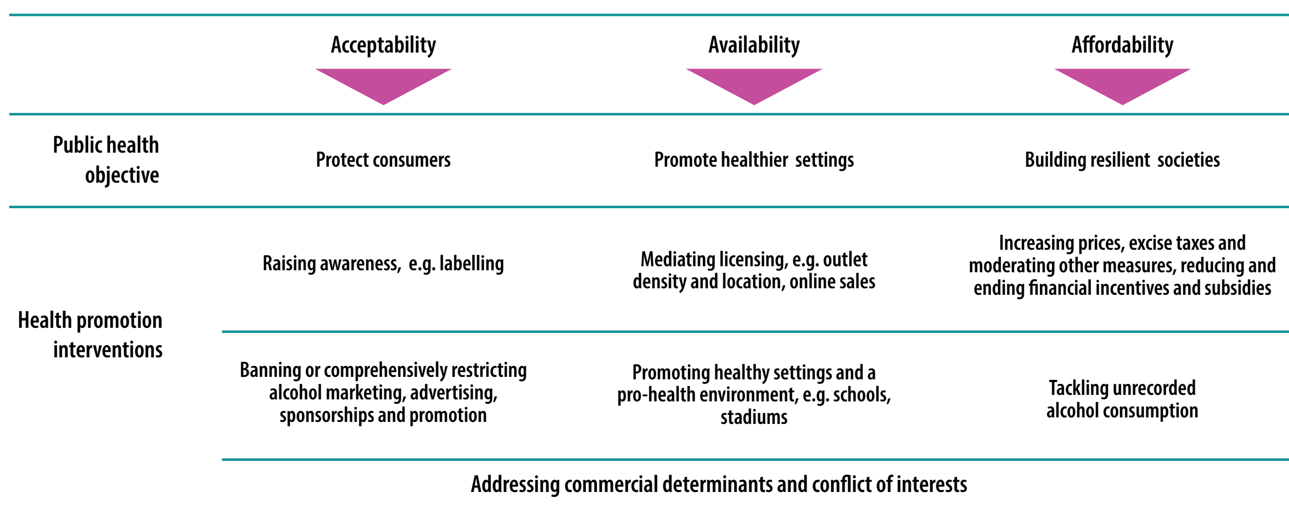
What is a health promotion approach to reducing alcohol consumption?

Drinking alcohol has multidimensional connotations. Robust and growing evidence demonstrates that cultural, social and religious norms influence consumption – acceptability, ease of purchase (availability) and price (affordability). Addressing this multidimensional causality chain requires a portfolio of health promotion interventions to moderate the determinants driving alcohol consumption and, in turn, enable populations to increase control over and improve their health to realize their full potential.

Interested in other topics?

The Less Alcohol webpage provides other briefs in this series and forthcoming webinars. Subscribe to the newsletter to be informed of new releases of briefs and notified of webinars to take part in these conversations. If you have a suggestion for a topic that has yet to be explored, contact the team at lessalcohol@who.int ■

Determinants driving the comsumption of alcohol



	Acceptability	Availability	Affordability
Public health objective	Protect consumers	Promote healthier settings	Building resilient societies
Health promotion interventions	Raising awareness, e.g. labelling	Mediating licensing, e.g. outlet density and location, online sales	Increasing prices, excise taxes and moderating other measures, reducing and ending financial incentives and subsidies
	Banning or comprehensively restricting alcohol marketing, advertising, sponsorships and promotion	Promoting healthy settings and a pro-health environment, e.g. schools, stadiums	Tackling unrecorded alcohol consumption
	Addressing commercial determinants and conflict of interests		

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BRIEF AT-A-GLANCE

The COVID-19 pandemic: implications on alcohol consumption and tobacco use

COVID-19 has caused severe social and economic disruptions and taken an incalculable toll on human health. The effects of the disease have been both direct, in terms of morbidity and mortality from the virus, and indirect, through strained health and social systems and the depression of global economies. The adoption of public health measures, including travel restrictions, physical distancing, and stay-at-home directives, has significantly changed how goods are produced, purchased, and consumed, including unhealthy commodities such as alcohol and tobacco. Throughout the pandemic, changes in the consumption of alcohol and tobacco have been observed, coupled with the increased likelihood of severe infections of COVID-19 among those who consume alcohol and use tobacco. In response, and to contend with these changes, countries in the WHO South-East Asia Region have implemented a range of policy approaches affecting the acceptability, availability and affordability of alcohol and tobacco.

A conceptual framework to approach the policy challenges

Addressing the multidimensional connotations of drinking alcohol and smoking tobacco requires a portfolio of population-wide interventions. A taxonomy of 25 variables for alcohol and 23 for tobacco was identified. Each variable represents a policy tool related to acceptability, availability or affordability.

Policy measures and regulatory changes during the COVID-19 pandemic

During the COVID-19 pandemic, countries in the South-East Asia Region adopted several policy measures to contend with acceptability, availability and affordability. Most of the efforts focused on changing acceptability and availability by, for example, raising awareness about the relationships between alcohol consumption and tobacco use and the severity of, and mortality from, COVID-19 infections. Similarly, many governments restricted the sale of alcohol on-premises and off-premises during the initial waves of the pandemic. In addition to changes in regulations, some countries strengthened their support to those who consume alcohol and use tobacco, for example, by increasing the availability of, and access to, telephone and virtual mental health supports. Significant participation by the alcohol and tobacco industry was also observed, primarily through corporate social responsibility initiatives.

Lessons learned from the COVID-19 pandemic

Five lessons were learned from findings across the 11 countries: i) the heavy focus on measures related to acceptability and availability of alcohol and tobacco; ii) the significant expansion of online ordering and home-delivery of alcohol and tobacco products; iii) the measures related to acceptability and availability are easier to implement and frequently under the purview of emergency acts; iv) the temporality of the measures reduced the potential for long-term gains in health and well-being that may have been experienced had these measures been sustained; and v) governments may struggle with feeling indebted towards the alcohol and tobacco industries following the COVID-19 pandemic.

Preparation for future pandemic events

The section brings together the findings from each of the 11 countries along with a synthesis of evidence collected during the pandemic. In the face of future public health emergencies, this brief suggests actions such as countries introducing stronger regulations to protect public health goals over vested interests; the exclusion of alcohol and tobacco from essential commodities lists; the expansion of services to support quitting and withdrawal; an increase in taxes levied on alcohol and tobacco; and the avoidance of implementing industry concessions, such as deferment of tax payments ■

THE COVID-19 PANDEMIC: IMPLICATIONS ON ALCOHOL CONSUMPTION AND TOBACCO USE

This section provides a brief overview of changes to alcohol and tobacco regulatory frameworks and their impact on acceptability, availability and affordability during the COVID-19 pandemic

COVID-19 context

On 11 March 2020, the World Health Organization declared COVID-19 a public health emergency of international concern *(1)*. Since then, COVID-19 has caused severe social and economic disruptions and an incalculable toll on human health worldwide. The effects of COVID-19 have been both direct, in terms of morbidity and mortality from the virus; and indirect, through strained health and social systems and the depression of global economies. The adoption of public health measures such as travel restrictions, physical distancing, and stay-at-home directives, has significantly changed how goods are produced, purchased, and consumed, including unhealthy commodities such as alcohol and tobacco. Although necessary to reduce infections, these measures may have also increased the risk associated with the consumption of these and other products. For example, stressors created during the pandemic, such as concerns for health, financial uncertainty and social isolation, may have translated into elevated psychological distress – a known correlate of smoking and drinking behaviour *(2, 3)*. Countries have implemented a range of policy approaches affecting the acceptability, availability and affordability of alcohol and tobacco to contend with these changes.

South-East Asia Region

Studies and systematic reviews conducted throughout the pandemic highlight that the effects of COVID-19 have not been evenly distributed throughout the globe, with many regions disproportionately affected. In particular, the WHO South-East Asia Region is the third most heavily affected by the pandemic *(3)* and is facing a socioeconomic crisis following its response. Limitations in the movement of people and the reduced flow of goods and services have affected populations greatly *(4)*. In addition, excess mortality in the region -the difference between reported COVID-19 deaths and deaths from all causes above and beyond what we expect to see during normal conditions-is 5.99 million, indicating a significant effect of crisis conditions on the health of the population *(5)*.

The WHO South-East Asia Region comprises 11 Member States and represents almost a quarter of the global population. The region was chosen as the focus for this policy brief because of the diversity of countries and cultures, different challenges to tackling harm from alcohol and tobacco, the variety of policy responses, and the availability of experiences in the public domain throughout the pandemic. Further, the region has a history of closely monitoring the use of unhealthy commodities, with one of the highest proportions of its population covered by tobacco surveillance. This policy brief builds on this tradition by examining the policy choices made by countries during the pandemic. It also aligns with current work in the Regional Action Plan to implement

the Global Strategy to reduce the harmful use of alcohol in the South-East Asia Region (2014-2025) *(6)*. While this WHO region and its 11 Member States are the primary focus of this study, a complementary policy brief is being completed for the WHO African Region. It is anticipated that the lessons learned from both documents can be contextualized and used to inform global policy decisions.

Alcohol and the COVID-19 pandemic

Excessive alcohol consumption has negative health consequences and is a risk factor for communicable and noncommunicable diseases, premature mortality, injury, and domestic violence, all of which have severe economic and societal costs *(7)*. Alcohol consumption also weakens the immune system, making individuals more susceptible to COVID-19 infection and increasing the risk of severe illness. Though the literature estimating the effects of alcohol consumption on COVID-19 severity is sparse, older literature found that alcohol consumption doubled the risk of developing severe acute respiratory syndrome *(8, 9)*. In addition, many of the conditions associated with alcohol consumption increase the risk of complications and death following a COVID-19 infection. For example, a systematic review found that mortality from COVID-19 among hospitalized patients with liver cirrhosis was twice likely as those without *(10)*. Similarly, studies have shown the mortality rate of COVID-19 patients with cancer – a known condition resulting from alcohol consumption – was higher than those without *(11)*. Given alcohol has both long- and short-term effects on the body, there is no safe limit to consumption.

During the early phases of the COVID-19 pandemic, there was a notable rise in the harmful use of alcohol, particularly among already heavy alcohol users *(12, 13)*. Higher levels of self-reported anxiety were correlated with increased self-reported heavy episodic drinking *(14)*. Evidence suggests that heavy alcohol consumption may increase during challenging times, such as crises and pandemics *(15-17)*. The high levels of stress experienced because of the COVID-19 pandemic may have generated physical and mental distress, leading to excessive drinking as a coping mechanism *(18)*.

However, some variation has been reported about the effects of the pandemic on alcohol consumption. For example, in some countries, those who consumed less alcohol prior to the pandemic were found to have decreased their intake throughout the pandemic *(19)*. One systematic review points to the variation being directly linked to the response strategies and differing cultural norms around alcohol consumption *(12)*.

Drinking practices that are detrimental to health, for example binge drinking, excessive drinking and underage drinking, have increased during the COVID-19 pandemic *(12, 20)*. Further, changes to the affordability and availability of alcohol include expanded online sales. The COVID-19 pandemic has impacted alcohol consumption in terms of the quantity, frequency and location of drinking, with possible long-term ramifications that may extend well beyond the pandemic duration *(19, 21)*.

Tobacco and the COVID-19 pandemic

Tobacco use is a significant risk factor for cardiovascular and respiratory diseases, more than 20 different types of cancer, and many other debilitating health conditions. Globally, every year, more than 8 million deaths are caused by tobacco use *(22)*. Of these, 1.6 million occur in the South-East Asia region *(6)*. Further, those who actively smoke experience more respiratory infections than non-smokers, including increased rates of influenza and pneumonia *(23)*. Around 29% of adults in the region are current tobacco users *(6)*.

Systematic reviews on the effects of COVID-19 among active smokers found that the behaviour was associated with increased severity of disease and death among those hospitalized for COVID-19 *(24, 25)*. For example, a recent meta-analysis found that smoking is a risk factor for severe COVID-19 illness and that those who smoke are 1.19 times more likely to die from COVID-19 than those who do not *(26)*. Similarly, those who used tobacco in the past but no longer consumed it were 1.15 times more likely to die from COVID-19 than those who never used tobacco.*(26)* In addition, tobacco-related conditions such as chronic obstructive pulmonary disease and coronary artery disease have been linked with increased odds of hospitalization, intensive care unit admission, and mortality from COVID-19 *(27-29)*.

Globally, the impact of the pandemic on smoking behaviour varies greatly. Some studies have found that people report smoking more than usual to reduce stress and loneliness at home. In contrast, others indicate that there has been a record number of individuals seeking to quit using tobacco due to its link to the acuity of COVID-19 infection *(30, 31)* ■

A CONCEPTUAL FRAMEWORK TO APPROACH THE POLICY CHALLENGES

This section provides a brief description of the approach and process used to identify regulatory changes to alcohol and tobacco control

Scope of the brief

This brief aims to identify the regulatory changes in alcohol and tobacco control adopted by countries of the WHO South-East Asia Region in response to the COVID-19 pandemic. The period of study was from 1 January 2020 to 30 June 2021; however, information about most of the applied measures was updated during the validation process.

The study focused on the 11 countries in the region: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

The outputs of the brief include an overview of the alcohol and tobacco regulation in each country, as well as lessons learned across the case–comparisons.

Conceptual framework

Addressing the multidimensional connotations of drinking alcohol and smoking tobacco requires a portfolio of population-wide interventions. Changes in regulatory frameworks guided by public health objectives are expected to moderate the determinants driving acceptability, availability, and affordability of these unhealthy commodities. During the COVID-19 pandemic, for example, public health objectives to protect people's health would lead to emergency measures to raise awareness, reduce the operating hours of sales outlets and increase excise taxes. The health promotion approach enables populations to increase control over and improve their health to realize their full potential.

A taxonomy of 25 variables for alcohol and 23 variables for tobacco was identified based on previous work, including from the Global Strategy to Reduce the Harmful Use of Alcohol and from a snapshot series on alcohol control policies and practices (32, 33). Each variable represents a policy tool related to the acceptability, availability or affordability of alcohol or tobacco. Experts in these topics were asked to review the taxonomy to ensure it was mutually exclusive and collectively exhaustive. The processes involved in developing the study are shown in Fig. 1 on page 5.

Sources of data and collection

The study was based on a comprehensive review of publicly available legal and policy documents published between 1 January 2020 and 30 June 2021. The documents were gathered from various online sources, including publications and press releases from official government websites and associated social media handles. The search focused on national and subnational legislation, bylaws such as regulations, rules, administrative action notifications, decrees, judicial rulings and official press releases. However, other sources were used to complement and cross-

check the information, including peer-reviewed articles, media news, civil society publications and reliable policy organizations such as The Union for tobacco. Non-official sources were used to triangle the information.

A search of the relevant legal and policy documents on the website COVID-19 Law Lab[1] was also conducted using the predefined categories of "movement and distancing restrictions" and "state of emergency/public health emergency".

For the Democratic People's Republic of Korea, the template was adapted to a questionnaire filled in by officials. The official responses were submitted and are reported in the analysis.

Structure of the template and questionnaire

An annotated template was developed to guide and ensure the harmonization of the data collection across countries. Local experts were engaged in collecting and analysing data and developing the initial country report. The template included a section to describe the overall implementation of legislation for tobacco and alcohol control and a section related to the legal measures adopted in response to the COVID-19 pandemic. The information about the legal measures adopted was structured to cover initiatives seeking to raise awareness (acceptability), reduce availability, and lessen the affordability of alcoholic beverages and tobacco products.

Management of the network of fieldwork experts

Experts were identified based on their regional and country expertise as well as experience working on regulating noncommunicable diseases. The study's

objectives and template were discussed with each local expert individually. Follow-up emails and video calls with the contributors took place during the data collection and development of the country reports. A coordinator ensured consistency across the different country reports.

In September 2021, a virtual meeting with local experts involved in the fieldwork served to streamline the drafting process, addressing common challenges faced during the data collection and identifying lessons learned for each country.

Validation process

A first validation step was undertaken by the technical officers in charge of alcohol and tobacco in each of the WHO country offices. The revisions informed the country reports, which were then shared with the national counterparts for review.

A summary table of findings and guidance were shared with each national counterpart to streamline the validation. The guidance sought the support of the national counterparts for alcohol and tobacco to confirm the information contained in the summary table, incorporate missing information and ensure the proper categorization of measures. The measures were categorized into those implemented in response to the COVID-19 pandemic; those adopted during the pandemic because they may have had an impact on coping with the pandemic; those unrelated to the pandemic and those adopted to protect public health or to accelerate economic recovery. Finally, the guidance requested that information related to the proposed measures that were not applied during the period of study, i.e. from 1 January 2020 to date, were updated. The follow-up and facilitation of this process were completed by the WHO country offices. The feedback was incorporated into a new draft of the country assessment reports.

Synthesis and analysis of findings across countries

The synthesis of findings across countries was carried out using the taxonomy of measures adopted to tackle the acceptability, availability and affordability of alcohol consumption and tobacco use (Table 1).

[1] See: https://covidlawlab.org/

Table 1. Overview of measures adopted

Acceptability	Availability	Affordability
Pre-existing ban on consumption	Restricting imports	Increasing import taxes
Essential commodity status	Restricting manufacture	Increasing VAT
Restricting use (e.g. smokeless tobacco, shisha)	Restricting on-premise sales (e.g. hotels, bars and restaurants)	Increasing excise tax – national
Banning spitting	Restricting off-premise sales (e.g. liquor and convenience stores, supermarkets, number of retailers)	Increasing excise tax – subnational
Raising awareness	Limiting hours of sales	Increasing goods taxes (e.g. goods and services tax, special goods tax, health risk tax)
Restricting advertisements	Restricting purchasing (e.g. by age, e-tokens, queuing)	Introducing a specific fees due to the COVID-19 pandemic
	Restricting online sales	
	Restricting home-delivery	

Additional measures included in the analysis consisted of strengthening addiction services, for example with toll-free smoking cessation hotlines, counselling and rehabilitation and restricting the industry's corporate social responsibility activities.

The findings across countries were analysed by experts, including WHO officials, to draw initial conclusions and policy recommendations. Experts included those with country and global-level experience with regulating commodities and noncommunicable diseases.

Development of the portfolio of lessons learned

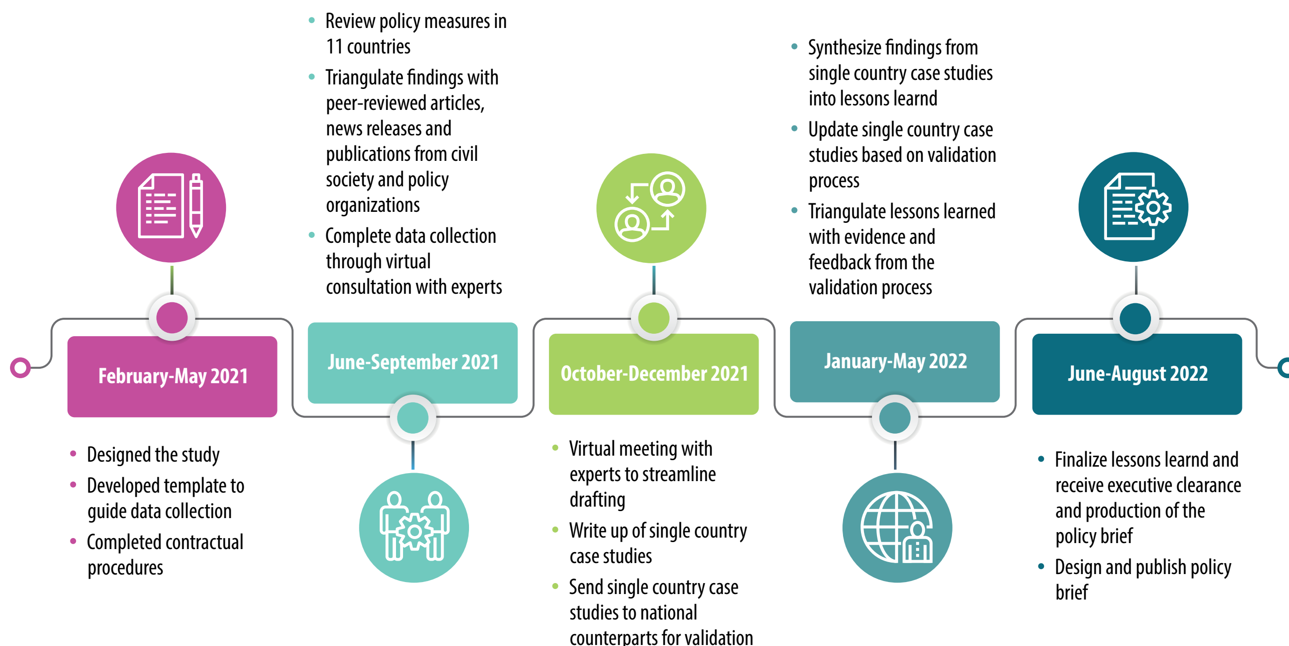
Lessons learned were to be developed based on three inputs: i) information extracted from country assessments; ii) a literature review of synthesized evidence published during the pandemic that related to each taxonomy variable and iii) evaluations identified during the validation process (though none were found). Synthesized evidence was drawn from the COVID-END inventory that can inform decisions related to the COVID-19 pandemic. The three data sources were triangulated to develop non-contextualized recommendations applicable to the national and subnational levels. They adopt public health and population-wide perspectives to protect health by addressing the acceptability, availability and affordability of alcohol beverages and tobacco products.

A virtual workshop was convened in June 2022 with the WHO staff from country offices, regional offices and headquarters to discuss lessons learned. During this event, staff presented their informed perspectives and were asked to submit any additional changes they may have. This process refined the lessons based on their input to ensure resonance before being included in the final report.

WHO quality assurance process

WHO has a three-step internal clearance process for publications. The Publications Review Committee oversees and gives clearances for all documents related to public health emergencies, including the COVID-19 pandemic. The decision of the Committee is made at the planning and final clearance stages to ensure relevance, consistency, methodological validity and compliance with quality standards.

Fig. 1. Stepwise process for the development of the study



Management of conflicts of interest

The contributors and editors involved disclosed no circumstances that could represent a potential conflict of interest in relation to the scope, development or outcome of this policy brief.

Limitations of this study

The study applies a structured review of publicly available legal and policy documents. The analysis maps and characterizes changes in regulatory frameworks but does not address the factors underpinning the political choices nor whether the policy objectives were achieved following the implementation of the regulatory changes.

This study has two limitations that should be acknowledged. The first is the period under which the study took place. Data were collected from countries between January 2020 and June 2021, leaving a significant portion of the pandemic – namely, the approaches governments took in dealing with the Omicron variant – out of data collection and analysis. Despite best efforts, it was not possible to collect the data retrospectively and thus, information from these 11 countries and what occurred after the initial waves of the pandemic is incomplete.

A second limitation is the lack of systematic evaluations of the effects of changes the countries made to the acceptability, availability and affordability of alcohol and tobacco. Throughout much of the brief, there is an implicit assumption that measures that reduce the acceptability, availability and affordability of alcohol and tobacco benefit the health and well-being of populations. However, it remains crucial to quantify the effects of these measures and document any unintended consequences or challenges in implementation to assess the feasibility of sustaining them over the long term ■

POLICY MEASURES ADOPTED DURING THE COVID-19 PANDEMIC

This section provides an overview of the measures taken by countries to tackle the acceptability, availability and affordability of alcohol and tobacco during the COVID-19 pandemic. Two summary tables, one for alcohol and one for tobacco, are provided at the end of each section

ALCOHOL

Tackling the acceptability of alcohol

During the pandemic, most countries (9 of 11 national governments) in the South-East Asia Region put in place regulatory measures that addressed the acceptability of alcohol. Among those implemented included some of WHO's "best buys" and recommended interventions to prevent noncommunicable diseases, including raising awareness about harm related to alcohol consumption and restricting advertisements of alcohol across multiple media types. Details on the regulatory measures enacted are summarized below *(34)*.

Raising awareness

Five countries (Democratic People's Republic of Korea, Indonesia, Myanmar, Sri Lanka and Thailand) launched awareness campaigns highlighting the association between alcohol consumption and the COVID-19 pandemic. Campaigns from these countries worked to dispel mistaken beliefs that consuming alcoholic beverages kills the COVID-19 virus while emphasizing the adverse association between alcohol consumption and COVID-19. This was achieved using a range of media platforms, including official addresses given to the public regarding COVID-19 and the regular publication of online and print media.

Restricting advertising

Though implemented prior to the pandemic, Sri Lanka was alone in restriction of advertisements. The Ministry of Health of Sri Lanka banned the promotion of alcoholic beverages in films, teledramas and songs on any media platform, including on social media.

Tackling the availability of alcohol

Enacting and enforcing restrictions on the physical availability of retail alcohol is another of WHO's "best buys" for cost–effective public health interventions for alcohol control *(34)*. Curfews and lockdowns affected the physical availability of alcohol across all countries. All but one country – the Maldives, which has a pre-existing ban on alcohol consumption – pursued additional interventions to restrict the availability of alcohol through the initial wave of the pandemic. The most prominent measures adopted by governments include restricting imports; restricting manufacture; restricting on-premise sales, such as in hotels, bars and restaurants; restricting off-premise sales, such as in liquor and convenience stores, and supermarkets; limiting hours of sales; and restricting online sales and home delivery. Details on the regulatory measures enacted are summarized below.

Restricting alcohol imports

Two countries, Nepal and Myanmar, implemented changes to their regulations on importing alcohol. However, the two experiences were very different. In March 2020, Nepal banned the import of international wine and spirits in an effort to safeguard the country's foreign currency reserve. This ban was lifted the following October. In contrast, while under significant economic pressure in May 2020, Myanmar lifted the foreign alcohol import ban that had been in place for health, social and religious reasons. The aim of easing restrictions was to improve the quality of national alcohol products, reduce contraband and illicit alcohol purchases, increase tax revenues, and attract foreign investment. This change in regulatory policy was a move to less restrictive approaches; the measure was supplemented with new guidelines on licensing rules and requirements for importing alcohol.

Restricting manufacturing

Another approach to tackle the availability of alcohol is to restrict its manufacturing. This measure was pursued solely by Sri Lanka, and for a short period of time only. On 20 March 2020, Sri Lanka declared a lockdown in response to the detection of local COVID-19 cases and banned the manufacturing of alcohol until 19 April 2020. However, after significant encouragement by the National Authority on Tobacco and Alcohol, among other stakeholders, the ban was reimposed on the sale of alcohol on 21 April 2020.

Restricting on-premise and off-premise sales and limiting hours of sale

The most widespread approach pursued by governments was to restrict (or change) on-premise and off-premise alcohol sales. During the early months of the COVID-19 pandemic, Bhutan closed duty-free stores that sold alcohol and tobacco products, as well as live music and entertainment venues, karaoke and snooker bars, discotheques, pubs and nightclubs. However, in October 2021, these were permitted to re-open at 50% capacity. In India, Nepal, Sri Lanka, Thailand and Timor-Leste, restrictions included closing restaurants, bars and hotels as well as limiting alcohol retail sales. In Timor-Leste, despite lockdown measures forcing the closure of bars and restaurants, supermarkets, mini-markets and groceries were permitted to operate – many of which sold alcoholic beverages. Although in India on- and off-market sales were restricted nationally, the states of Kerala and Punjab declared alcoholic beverages essential commodities, exempting them from the national regulations.

After the first wave of the pandemic, many governments relaxed restrictions to resume economic operations but later reimposed them in response to surges in COVID-19 cases. For example, Thailand implemented zone-specific measures that affected the availability of alcohol differently depending on COVID-19 infections. In India, state authorities re-opened on-premise alcohol establishments in parallel with the gradual resuming of the economy: liquor could be served in hotel rooms and restaurants, however bars in hotels remained closed. Restaurants were also allowed to remain open until 21.00 hours with up to 50% occupancy.

Restricting online sales and restricting home-delivery

The final regulatory approach that governments pursued was restricting (or changing) online sales. Bhutan and India allowed the online sale and home delivery of alcohol. In India, different states adopted different approaches, which included the issuing of e-tokens for pick up, online purchases, and home delivery either by the retailer or by a third party. Conversely, Indonesia and Thailand prohibited the online sale and home delivery of alcohol. Thailand banned the online sale, advertisement and marketing of alcoholic beverages in December 2020; Indonesia banned online sales for a few months because the country had no regulatory framework. In Sri Lanka, despite efforts from the Ministry of Finance to allow online sales, public health objectives prevailed.

Tackling the affordability of alcohol

The final subset of policy and regulatory approaches focuses on changing the price of alcohol consumption. Increasing alcoholic beverage excise taxes is one of the most cost–effective "best buys" for reducing the harmful use of alcohol, with high feasibility in many countries, including in low- and middle-income countries *(34)*.

Changing import and excise taxes

Four countries (India, Maldives, Nepal and Timor-Leste) increased taxes on alcohol products during the COVID-19 pandemic. In India, increased taxes were pursued at a subnational level in at least 11 states, which imposed additional taxes, including import and excise taxes, to generate additional revenue. These additional taxes were imposed for a limited duration, in most cases for the initial few months of the first COVID-19 wave and varied from 10% to 70% depending on the state.

Maldives and Timor-Leste also increased taxes on alcoholic beverages, although this was not associated with the COVID-19 pandemic. Whereas the Maldives introduced an amendment to the export–import act that levied a 25% increased import tax, variable on the type of alcohol, Timor-Leste began a systematic increase in excise tax levied on alcoholic beverages to disincentivize consumption and raise revenues.

On the contrary, Nepal did not increase excise duty on alcohol products in its 2020/21 budget to mitigate the negative impact of the COVID-19 pandemic on the alcohol and hospitality industry. Similarly, Indonesia granted a deferral of excise tax payment from 60 to 90 days to inflow cash for businesses.

Special goods tax

Contrary to the other approaches which levy a tax upon import or manufacturing, Myanmar increased the special goods tax on alcohol at the point of sale and increased the minimum price of alcohol from 200 to 300 Myanmar kyats.

Other measures

Strengthening addictions services

In addition to regulatory efforts aimed at raising awareness about the harms of alcohol and restricting advertising, two countries, Bhutan and Thailand, strengthened addiction services as part of their pandemic response. To support those with alcohol dependence disorders through lockdown measures and changes in the availability of alcohol, Bhutan established a dedicated mental health hotline, a National Mental Health Response Team, and guaranteed a supply of alcohol for those with severe withdrawal symptoms.

Industry participation

During the initial days of the pandemic, the industry was called upon to support governments in their response to the pandemic, in particular, to procure and produce needed goods. For example, in Indonesia, Multi Bintang, the largest domestic brewery in the country, produced masks and donated hand sanitizers. At the same time, Myanmar received ventilators, patient monitors and oxygen concentrators from Brewery Limited, and in both Bangladesh and India, factories producing alcohol were repurposed to manufacture sanitizers.

These actions were undoubtedly important aspects of initial pandemic responses and helped to replenish country stockpiles; nonetheless, they should be interpreted in the context of corporate social responsibility. In supporting government responses, the actions of the industry were not solely altruistic: they were also used to place alcohol companies and their products in a positive light. For example, in India, activities of the alcohol industry included direct financial contributions to citizen assistance and relief funds while simultaneously pushing for resumed alcohol sales to assist states in providing minimum subsistence allowance, free food and health care in resource-constrained times. Their participation in the response helped to legitimize the industry's role in the policy process, setting a concerning precedent for the development of future public health regulations ■

Table 2. Regulatory measures on alcohol products enacted during the COVID-19 pandemic*

Country	Acceptability	Related to COVID-19 response? (dates implemented)	Comments	Availability	Related to COVID-19 response? (dates implemented)	Comments	Affordability	Related to COVID-19 response? (dates implemented)	Comments
Bangladesh	Pre-existing ban on consumption	No (1990–)	Permit required to consume	Restricting on-premises sales	Yes (no dates reported)	Bars closed	–	–	–
	Implementing health warning labels	No (2022 -)	Alcohol bottles must include a health warning labelling	Restricting off-premises sales	Yes (no dates reported)	During the first wave (March 2020)	–	–	–
Bhutan	–	–	–	Restricting on-premises sales	Yes (no dates reported)	–	Increasing goods taxes	No (July 2021–)	Increasing goods and services tax not linked to COVID. Implementation in July 2022
	–	–	–	Restricting off-premises sales	No (no dates reported)	Replacement of private outlets with temporary state-run outlets	–	–	–
	–	–	–	Limiting sales hours	Yes (March 2020– October 2021)	–	–	–	–
	–	–	–	Permitting online sales	Yes (August 2020–)	–	–	–	–
	–	–	–	Permitting home-delivery	Yes (August 2020–)	–	–	–	–
Democratic People's Republic of Korea	Raising awareness	Yes (no dates reported)	–	Restricting manufacturing	No (no dates reported)	Government regulates the production and distribution of alcohol	–	–	–
	Restricting advertisement	No (no dates reported)	No advertisements for alcoholic beverages are permitted on television or other media sources	Restricting on-premises sales	No (no dates reported)	Government regulates the sale of alcohol	–	–	–
	–	–	–	Restricting online sales	No (no dates reported)	Online sales are not permitted	–	–	–

Country	Acceptability	Related to COVID-19 response? (dates implemented)	Comments	Availability	Related to COVID-19 response? (dates implemented)	Comments	Affordability	Related to COVID-19 response? (dates implemented)	Comments
India	Essential commodity – subnational	Yes (no dates reported)	In Kerala and Punjab	Restricting manufacture	Yes (March 2020–May 2020)	Only during the first wave/lockdown	Increasing import taxes – subnational	Yes	For revenue generation in Punjab
	–	–	–	Restricting on-premises sales – subnational	Yes (dates differed subnationally)	During the first wave/ lockdown, nationally, except in Kerala and Punjab where alcohol was categorized an essential commodity. In Punjab, ahatas not allowed during other lockdowns	Increasing excise tax – subnational	Yes	For revenue generation in Andhra Pradesh, Assam, Delhi, Haryana, Karnataka, Meghalaya, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, West Bengal
	–	–	–	Restricting off-premise sales	Yes (dates differed subnationally)	Except in Kerala and Punjab where alcohol was categorized an essential commodity. Restrictions on hours of sale were applied subnationally	Introducing special or COVID fees – subnational	Yes	For revenue generation in Chhattisgarh, Delhi, Odisha
	–	–	–	Limiting hours of sales	Yes (dates differed subnationally)	Regulating hours of sale in Andhra Pradesh, Chhattisgarh, Delhi, Karnataka, Maharashtra, Odisha, Punjab, Uttar Pradesh, West Bengal	–	–	–
	–	–	–	Restricting purchasing	Yes (dates differed subnationally)	E-token system in Delhi and Maharashtra. Delhi decreased the drinking age from 25 to 21 years	–	–	–
	–	–	–	Permitting online sales	Yes (dates differed subnationally)	Permitted in Chhattisgarh, Karnataka, Maharashtra and Odisha	–	–	–
	–	–	–	Permitting home-delivery	Yes (dates differed subnationally)	Permitted in Chhattisgarh, Delhi, Maharashtra, Mumbai, Odisha, Punjab	–	–	–
Indonesia	Raising awareness	Yes (March 2020)	Addressing misinformation	Restricting online sales	Yes (April 2020–July 2020)	–	Deferring excise tax (April 2020–June 2020)	No	Deferral of 90 days for inflowing cash to the business
Maldives	Pre-existing ban on consumption	Yes (no dates reported)	–	–	–	–	Increasing excise tax- national	Yes (July 2020–)	Not linked to COVID

Country	Acceptability	Related to COVID-19 response? (dates implemented)	Comments	Availability	Related to COVID-19 response? (dates implemented)	Comments	Affordability	Related to COVID-19 response? (dates implemented)	Comments
Myanmar	Raising awareness	Yes (September 2020)	Addressing misinformation	Lifting import restrictions	Yes (May 2020–)	Lifting the foreign liquor import ban	Increasing goods taxes	Yes (2020–)	Increasing special goods tax not linked to COVID
	–	–	–	Restricting on-premise sales	Yes (April 2020–)	Some subnational authorities (i.e. Yangon city, Mandalay and Lashio), imposed restrictions earlier	–	–	–
Nepal	–	–	–	Restricting import	Yes (March 2020–October 2020)	Safeguarding foreign currency reserves	Deferring excise tax – national	No (2020–2021)	Purposely postpone by 1 year the increase in taxes to support economic recovery
	–	–	–	Restricting on-premises sales	Yes (March 2020–July 2020 and then at the discretion of the subnational level)	–	–	–	–
	–	–	–	Restricting off-premises sales	Yes (March 2020–July 2020)	–	–	–	–
Sri Lanka	Raising awareness	Yes (no dates reported)	–	Restricting manufacture	Yes (April 2020–June 2020)	–	–	–	–
	Restricting advertisement	No (no dates reported)	Ban on media promotion implemented prior to the pandemic	Restricting on-premises sales	Yes (March 2020–June 2020)	–	–	–	–
	–	–	–	Restricting off-premises sales	Yes (March 2020–May 2020)	–	–	–	–
	–	–	–	Restricting online sales	No	Implemented prior to the pandemic	–	–	–
	–	–	–	Limiting sales hours	Yes (March 2020–June 2020)	–	–	–	–
	–	–	–	Restricting purchasing	Yes (March 2020–June 2020)	–	–	–	–
	–	–	–	Restricting home-delivery	No	Implemented prior to the pandemic	–	–	–

Country	Acceptability	Related to COVID-19 response? (dates implemented)	Comments	Availability	Related to COVID-19 response? (dates implemented)	Comments	Affordability	Related to COVID-19 response? (dates implemented)	Comments
Thailand	Raising awareness	Yes (April 2020–)	–	Restricting on-premises sales	Yes (April 2020–June 2020)	Additional restrictions were regionally imposed following the first wave based on the prevalence of COVID-19	–	–	–
	–	–	–	Restricting off-premises sales	Yes (no dates reported)	–	–	–	–
	–	–	–	Limiting sales hours	Yes (no dates reported)	–	–	–	–
	–	–	–	Restricting online sales	Yes (December 2020–)	–	–	–	–
Timor-Leste	–	–	–	Restricting on-premise sales	Yes (September 2021–)	–	Increasing excise tax	Yes (2020–)	Not linked to COVID
	–	–	–	Restricting off-premise sales	No (September 2021–)	Groceries were exempted from closure and also sold alcoholic beverages	–	–	–
	–	–	–	Restricting purchasing	No (no dates reported)	Pre-existing lack of clearly-defined minimum drinking age	–	–	–

*Where dates of implementation and cessation of policies and regulations are known, they have been noted. However, this information was not always publicly available. Policies and regulations with no end date are either in place (frequently the case for changes to financial regulations), or the end date was not publicly available.

TOBACCO

Tackling the acceptability of tobacco

During the COVID-19 pandemic, governments used different approaches to change the acceptability of tobacco; these included raising awareness about harm related to tobacco, restricting advertisements, and intensifying labelling requirements on tobacco packaging. Details on the regulatory measures enacted are summarized below.

Raising awareness

Implementing effective mass media campaigns to educate the public about the harms of smoking, tobacco use and second-hand smoke is one of the WHO "best buys" public health interventions for tobacco control with cost–effectiveness and feasibility in implementation in countries, including low- and middle-income countries *(34)*. Article 12 of the WHO Framework Convention on Tobacco Control requires parties to promote and strengthen public awareness of tobacco control issues and the benefits of the cessation of tobacco use, using all available communication tools.

Of the 11 countries, five governments (Bangladesh, Democratic People's Republic of Korea, Myanmar, Nepal, and Thailand) carried out extensive public awareness campaigns centred around the health risks of tobacco use and the COVID-19 pandemic. Myanmar conducted a national communication campaign across media platforms, including radio, social media and national newspapers, between April and November 2020. The campaign highlighted the increased risk of severe COVID-19 outcomes for tobacco users and encouraged positive behaviour change by reducing or quitting tobacco use.

Both Thailand and Nepal conducted extensive campaigns during the 2020 and 2021 World No Tobacco Day, urging individuals to quit tobacco use and highlighting the increased risk of severe COVID-19 disease among tobacco users. Thailand focused its communication strategy on smoking cessation and youth initiation and encouraged the use of a toll-free national smoking cessation hotline for individuals willing to quit. The authorities in Thailand ultimately dismissed as unreliable and biased, research that suggested smoking as a preventive measure for COVID-19 and urged individuals to rely on the recommendations of public health authorities for information related to COVID-19. Bangladesh, the Democratic People's Republic of Korea and Nepal all carried out similar communications focused on educating the public on the link between tobacco use and adverse COVID-19 health outcomes.

Restricting advertisements

Although unrelated to the COVID-19 pandemic, India made concurrent significant changes to advertising regulation, including prohibiting tobacco advertisements on internet-based platforms and social media.

Tackling the availability of tobacco

A range of policy approaches was used that directly or indirectly restricted the availability of tobacco. These primarily focused on restricting the manufacturing of tobacco, as well as restricting on-premise and off-premise sales, home delivery and online sales. Many positive steps were taken during the initial wave of the pandemic, however some governments chose to expand the availability of tobacco due to concerns about cross-border black market tobacco sales. Details on the regulatory measures enacted are summarized below.

Restricting the manufacturing of tobacco

Of the 11 countries, India was alone in shutting down tobacco manufacturing temporarily during the pandemic. The first nationwide lockdown on 25 March 2020 resulted in a ban on manufacturing and selling tobacco products *(35)*. However, manufacturing resumed in May 2020 alongside new tobacco sales and use regulations.

Restricting on-premise and off-premise sales

The imposed curfews and lockdowns that restricted movement and commercial activities during the COVID-19 pandemic impacted the retail sales of tobacco products in many countries. Tobacco retail was prohibited in five of the 11 countries, either directly by the government or indirectly through lockdown restrictions. The Maldives temporarily restricted the use and sale of shisha in eateries, bars, and public places in March 2020, while Nepal imposed a nationwide lockdown, prohibiting the operation of all public and private sector services.

The declaration of a state of emergency in Thailand in March 2020 limited the sale of tobacco products

due to restrictions in the hours of operations of stores and markets. Thailand, on several occasions, limited the operating hours of 24-hour convenience stores that also sold tobacco products. Likewise, Sri Lanka instructed business owners and employers to restrict the sale of tobacco products and prohibit their sale and use at social gatherings. This measure was implemented to reduce the increased risk of COVID-19 infection among smokers and spitting from chewing tobacco.

On 25 March 2020, a nationwide lockdown in India resulted in a ban on the sale of tobacco products; this was followed by a further strict ban on the sale of gutkha and tobacco products in April 2020. In the same month, the Indian Council of Medical Research issued a nationwide appeal urging people to stop using smokeless tobacco products and spitting in public places. This advisory was followed by a ban on spitting in public places enforced, along with another urging state authorities to prohibit the sale and use of smokeless tobacco products in public places. The advisory stated that "chewing smokeless tobacco products, *paan* masala and areca nut (*supari*) increases the production of saliva followed by a strong urge to spit. Spitting in public places could facilitate the spread of the COVID-19 virus".

While many governments implemented measures restricting the sale of tobacco products during the pandemic, Bhutan witnessed a historic shift in its tobacco control policy. Bhutan, one of the first countries to ban the sale of tobacco products and smoking in public places, repealed the tobacco ban in 2021 through an amendment to its tobacco control law. This change in approach was implemented to reduce the risk of cross-border COVID-19 infections due to the smuggling of tobacco into Bhutan. The 2021 amendment to the Tobacco Act legalized the sale, purchase, possession, distribution and transportation of tobacco products; manufacturing and production remained illegal. The ban was lifted, and temporary tobacco sale outlets were established, to curb COVID-19 infections stemming from cross-border black market tobacco sales. In August 2020, for the first time, Bhutan also temporarily permitted the home delivery of tobacco products to prevent violating the lockdown protocol. Similarly, in Bangladesh, tobacco retail and industry operations remained uninterrupted as manufacturing, leaf purchase, finished goods supply and distribution of cigarettes during the pandemic conformed with the 1956 Essential Commodities Act, which classified cigarettes as an essential commodity.

Tackling the affordability of tobacco

Increasing taxes and prices on tobacco products is also one of the WHO "best buys" public health interventions for tobacco control with high cost–effectiveness and feasibility in implementation in low- and middle-income countries *(34)*. Further, Article 6 of the WHO Framework Convention on Tobacco Control obligates contracting parties to implement tax policies and, where appropriate, price policies on tobacco products to contribute to the health objectives of reducing tobacco use. Effective taxes on tobacco products that lead to higher consumer prices are proven to lower tobacco use.

During the COVID-19 pandemic, five of the 11 countries increased taxes, including excise and import taxes as well as a special goods tax on tobacco products. These increases were not necessarily associated with the COVID-19 pandemic and, in some cases, can be explained by the regular adjustments to inflation rates.

Increasing excise and import taxes

In June 2020, Indonesia issued a decree establishing an excise tax to control tobacco use that could be used to fund healthcare due to the high burden of tobacco-related diseases and strengthen health systems that were under strain due to the rising COVID-19 cases *(36)*. Each year, Indonesia puts forward a tax increase of approximately 25. However, despite those clearly expressed needs, in February 2021, a conservative increase of 12.5% was implemented. The more conservative 12.5% increase was justified by the need to balance efforts to reduce smoking and the need to support the tobacco industry's economic recovery.

Although not linked to the pandemic, in July 2020, taxes were raised in the Maldives using an amendment that increased the price per cigarette stick from 2 to 3 Maldivian rufiyaa. Tax on e-cigarettes was also levied at 200% *(37)*. The amendment requires that 3% of the proceeds from import duties levied on tobacco products be deposited to the Public Health Fund established by the 2012 Public Health Protection Act (Law No. 7) to finance anti-tobacco public health awareness campaigns *(38)*. Similarly, in the health risk tax, introduced in 2018, on bidis, cigarettes, cigars, tobacco, gutkha and pan masala. Rates were raised to 25 Nepalese paisa per bidi, 50 per cigarette and 40 Nepalese rupees per kilogramme, at the time of import or dispatch for production *(39)*.

Increasing special goods taxes

In Myanmar, the 2020 Union Taxation Law increased the special goods taxes on cigarettes and cheroots *(40)*.

Cheroot taxes were raised from 0.75 Myanmar kyats (75 US cents) per item in 2019 to 0.80 kyats (80 US cents) in 2020. Cigarette taxes increased from 8 Myanmar kyats per cigarette in 2019 to 9 kyats in 2020 *(41)*.

Alongside an increase in excise tax, in November 2020, Sri Lanka introduced a new Goods and Service Tax on cigarettes, replacing several taxes with a single tax. In June 2021, the National Authority on Tobacco and Alcohol developed a uniformed tobacco taxation module considered an exemplar in levying taxes that comprise at least 75% of retail pricing *(42)*. In April 2021, Sri Lanka reached 77% of the retail price of the most popular brand, effectively lowering both the affordability and usage of tobacco products *(43)*.

Additional changes to taxation

One of the main principles outlined in the guidelines of the WHO Framework Convention on Tobacco Control for implementing Article 5.3 is to refrain from granting incentives to the tobacco industry to establish or run their businesses. Nonetheless, governments introduced measures during the COVID-19 pandemic to grant financial support to the tobacco industry. In April 2020, Indonesia granted a deferral of excise tax payment to factory entrepreneurs or importers of excisable goods, including tobacco products, from the original 60 days to 90 days. This relaxation aimed to assist entrepreneurs in strengthening cash flow during the pandemic that affected economic stability and industrial productivity. Bhutan, in 2021, lifted its 100% sales tax on tobacco products by enacting the 2021 Tax Bill as an interim measure to prevent the spread of the virus through the anticipated smuggling and black marketing of tobacco products through the southern borders. Bhutan has also enacted the Goods and Services Tax Act which would reinstate the 100% sales tax on tobacco products in July 2022.

Industry participation

Of the 11 countries, six showed evidence of industry participation both by way of corporate social responsibility activities to support government pandemic efforts and, in some instances, evidence of direct interference in policy-making. As with the initiatives of alcohol companies, the tobacco industry directly donated to government funds or was involved in distributing masks, hand sanitizers, food supplies, hospital equipment and personal protective equipment. For example, the state-owned tobacco enterprise, Tobacco Authority of Thailand, distributed hand sanitizers, survival kits comprising rice, dry food, and drinking water and established a COVID-19 Consultation Hotline to facilitate quick redressal of public queries relating to the disease. In March 2020, Myanmar Traditional Cheroot Producers Association donated US$ 25 000 to the National Central Committee on Prevention, Control and Treatment of COVID-19, publicly received by the Minister for Health and Sports. Myanmar adopted a directive containing guidelines for engaging with the tobacco industry; however, there is a lack of evidence to suggest a link between the pandemic and this directive.

In April 2020, Djarum, a leading cigarette manufacturer in Indonesia, donated ventilators, masks, protective goggles and personal protective equipment, while the Gudang Garam, a clove cigarette manufacturing company, donated an ambulance to support the operations of the Indonesian Red Cross in Kediri to respond to emergency needs during the pandemic. Sampoerna, a leading subsidiary of Philip Morris in Indonesia, partnered with the Chamber of Commerce and Industry to build infrastructure and supporting facilities for a COVID-19 vaccination centre.

Almost all tobacco companies in India employed corporate social responsibility activities and extensively with official agencies, nongovernmental organizations and celebrities. Between March 2020 and June 2020, the tobacco industry pledged approximately US$ 36.7 million to various state funds, including direct financial contributions and the distribution of ventilator machines, masks and personal protective equipment, food and hand hygiene essentials and promoted awareness campaigns on the use of masks, social distancing and handwashing *(44)*. Dharampal Satyapal Group, a major smokeless tobacco manufacturer in India, leveraged its corporate social responsibility activities in response to public interest litigation filed against lifting the ban on the manufacture and sale of smokeless tobacco products *(44)*.

Unlike the earlier examples of corporate social responsibility, the tobacco industry directly interfered in policy-making in Bangladesh. British American Tobacco and Japan Tobacco International requested that the Ministry of Industries advise civil administration and law enforcement authorities to facilitate continuous manufacturing, leaf purchase, finished goods supply and distribution of cigarettes based on the 1956 Essential Commodities Act. To support COVID-19 relief, both British American Tobacco and Japan Tobacco International provided corporate social responsibility donations to Bangladesh and its agencies through personal protective equipment and sanitizers. In Nepal, the Kathmandu Institute of Child Health rejected a donation of US$ 400 000 offered by Surya Nepal Pvt. Ltd., a leading manufacturer of tobacco products ■

Table 3. Regulatory measures on tobacco products enacted during the COVID-19 pandemic*

Country	Acceptability	Related to COVID-19 response? (dates implemented)	Comments	Availability	Related to COVID-19 response? (Dates implemented)	Comments	Affordability	Related to COVID-19 response? (dates implemented)	Comments
Bangladesh	Essential commodity	Yes (no dates reported)	Confirming tobacco as an essential commodity	–	–	–	Increasing excise tax	No (no dates reported)	Excise tax has been increased following regular practice
	Raising awareness	Yes (no dates reported)	–	–	–	–	–	–	–
	Banning smoking - national	No (no dates reported)	Pre-existing ban on smoking in select public areas was continued	–	–	–	–	–	–
	Banning spitting-national	No (no dates reported)	Pre-existing ban in certain areas was continued	–	–	–	–	–	–
Bhutan	–	–	–	Lifting ban	Yes	Legalizing sale, purchase, possession, distribution and transportation	Freezing import taxes	Yes (March 2021 – July 2022)	Waiver on 100% sales and customs tax. To be reinstated in July 2022.
	–	–	–	Restricting off-premises sales	Yes (March 2020– -)	Replacement of private outlets with temporary government outlets	–	–	–
	–	–	–	Restricting purchasing	Yes (July 2021– -)	Reducing the number of retailers	–	–	–
	–-	–	–	Limiting sales hours	Yes (March 2020 – October 2021)	–	–	–	–
	–-	–	–	Introducing home delivery	Yes (August 2020–)	–	–	–	–

Country	Acceptability	Related to COVID-19 response? (dates implemented)	Comments	Availability	Related to COVID-19 response? (Dates implemented)	Comments	Affordability	Related to COVID-19 response? (dates implemented)	Comments
Democratic People's Republic of Korea	Raising awareness	Yes (November 2020 –)	Public health institutes, mass media and other institutes are asked to advocate the harmfulness of tobacco and its correlation with more acute cases of COVID-19	Restricting purchasing	No (November 2020 –)	Only designated outlets are permitted to sell tobacco	Increasing import taxes	No (November 2020 –)	High tariffs are in place on the importation of tobacco and its raw materials
	Restricting advertisement	No (November 2020 –)	Plain packaging is required on all tobacco and advertising tobacco sale has been banned	Banning use	No (November 2020 –)	Smoking is banned in select public places, including nurseries, schools, health facilities, and public transportation	–	–	–
India	Restricting advertisement	No (December 2020)	–	Restricting manufacture	Yes (March 2020 – May 2020)	Nationally, lifted after industry interference	–	–	–
	Restricting use – subnational- sub national	Yes (State dependent)	Ban on smokeless tobacco in 23 states (i.e Bihar, Delhi and Telangana)	Restricting off-premises sales	Yes (May 2020 –)	–	–	–	–
	Banning spitting –- national	Yes (April 2020)	–	–	–	–	–-	–	–
Indonesia	Raising awareness	Yes (March 2021 –)	–	–-	–	–	Deferring excise tax	Yes (April 2020 – May 2020)	Deferral of 90 days for inflowing cash to the business
	Restricting use –- subnational	Yes (May 2021 –)	The city of Bandung restricted smoking in seven public places	–	–	–	–	–	–
Maldives	Restricting use	Yes (March 2020 –)	Ban on shisha	–	–	–	Increasing import taxes	No (July 2020 –)	Not linked to COVID
Myanmar	Raising awareness	Yes (April 2020 – November 2020)	Established the ""Let's Beat COVID Together"" campaign	–-	–	–	Increasing goods taxes	Yes (January 2020)	Increasing special goods tax not linked to COVID
	Restricting advertisement	No (2021–)	Enacted standardized packaging	–	–	–	–	–	–

Country	Acceptability	Related to COVID-19 response? (dates implemented)	Comments	Availability	Related to COVID-19 response? (Dates implemented)	Comments	Affordability	Related to COVID-19 response? (dates implemented)	Comments
Nepal	Raising awareness	Yes (March 2020 –)	Public anti-tobacco campaigns	Restricting off-premises sales	Yes (March 2020 –)	Ban on sale – subnational- sub national	Increasing excise tax	Yes (2020 –)	Routine practice not linked to COVID
	– -	–	–	–-	–	–	Increasing goods taxes	Yes (2021–)	Increasing health risk tax not linked to COVID
Sri Lanka	Raising awareness	Yes (June 2020 –)	–	Permitting online sales	Yes (March 2020 – June 2020)	–	Increasing excise tax	Yes (November 2020 –)	New Goods and Service Tax at 77%
	–-	–	Ban on media promotion	Permitting home delivery	Yes (March 2020 – June 2020)	–	–-	–	–
Thailand	Raising awareness	Yes (March 2020 – January 2021)	2020 World No -Tobacco Day campaigns	Limiting sales hours	Yes (2020–-2021)	–	–	–	–
Timor-Leste	–	–	–	Restricting off-premises sales	No (no dates reported)	Groceries were exempted from closure and also sold tobacco products	–	–	–

*Where dates of implementation and cessation of policies and regulations are known, they have been noted. However, this information was not always publicly available. Policies and regulations with no end date are either still in place (frequently the case for changes to financial regulations),) or the end date was not publicly available.

LESSONS LEARNED FROM THE COVID-19 PANDEMIC

This section summarizes lessons learned emerging from diverse settings across the WHO South-East Asia Region that can help to inform other countries' responses to future public health emergencies. Significant policy and regulatory changes occurred across the 11 countries of the WHO South-East Asian Region during the COVID-19 pandemic. Six lessons emerged to dictate the acceptability, availability and affordability of alcohol consumption and tobacco use during a public health crisis

HEAVY FOCUS ON MEASURES RELATED TO ACCEPTABILITY AND AVAILABILITY OF ALCOHOL AND TOBACCO

1 All countries implemented measures relating to either alcohol or tobacco that altered the acceptability and availability of these two commodities. However, comparably few governments pursued measures concerning affordability; those that did were rarely linked directly to the pandemic. This partly results from many measures relating to acceptability and availability being knock-on effects of initial pandemic regulations rather than deliberate policy choices. For example, the primary objective of lockdowns and the closing of shops and bars was to limit social gatherings and the spread of COVID-19. Restrictions on weddings and other family gatherings were critical in reducing not only the spread of COVID-19 but also alcohol consumption. The knock-on effect of these choices was the reduction in purchasing hours for alcohol and tobacco. Similarly, communications during the pandemic were frequently targeted at combating misinformation about the protective factors of alcohol consumption and tobacco use rather than raising awareness more generally about the risks and their links to communicable and noncommunicable diseases.

SIGNIFICANT EXPANSION OF ONLINE ORDERING AND HOME -DELIVERY OF ALCOHOL AND TOBACCO PRODUCTS

2 Lockdowns implemented in the initial wave of the COVID-19 pandemic resulted in significant changes to the availability of alcohol and tobacco products. In response, the industry accelerated online purchasing and home delivery which not only significantly increased availability, making consumption and use more convenient, but also risked supplying younger underage persons with the possible associated increased risks and harms in consumption and use *(45)*. Although the increase in online sales has been a significant focus in alcohol regulation throughout the pandemic, it has also taken shape for tobacco products – mainly through the online sale of e-cigarettes and e-cigarette fluids. Despite the significant risk posed, only five countries restricted online sales or home delivery of alcohol during their pandemic responses and only two countries on tobacco products. However, unlike many of the corresponding restrictions (which were frequently part of emergency acts), it is unlikely that online sales and home delivery will cease following the pandemic and countries should prepare to examine long-term solutions to reduce the availability of these products and safeguard younger generations. One solution may be through advocacy at the policy level, which resulted in the withdrawal of online sale platforms in several states in India and Thailand after repeated advocacy on the harmful effects on communities.

MEASURES RELATED TO ACCEPTABILITY AND AVAILABILITY ARE EASIER TO IMPLEMENT AND FREQUENTLY UNDER THE PURVIEW OF EMERGENCY ACTS

3 The enactment of measures related to the acceptability and availability of alcohol and tobacco may have been popular choices among countries as they are relatively easy to implement and frequently under the purview of governments' emergency measures acts, as opposed to changes in taxation which may require a longer legislative process and have the potential for pushbacks. Countries that focused on affordability frequently did so at the import or manufacturing stages; levying import or excise taxes rarely translated into increases in prices at the point of consumption. This is widely agreed to be one of the most effective means of controlling alcohol consumption and tobacco use, so long as the tax levied is sufficient to trickle down to the consumer. Although relatively few countries stated that increases in taxes were associated with the pandemic, they co-occurred with other mitigation efforts. Instead, many of the changes to affordability may have been advanced to keep pace with inflation, garner revenues or support the economic recovery.

THE TEMPORALITY OF THE MEASURES REDUCED THE POTENTIAL FOR LONG-TERM GAINS IN HEALTH AND WELL-BEING THAT MAY HAVE BEEN EXPERIENCED HAD THESE MEASURES BEEN SUSTAINED

5 Changes in policies and regulations were frequently pursued for relatively short periods of time. As the primary objective of the changes was to reduce the spread of COVID-19, they were frequently reversed following the first or second wave – once governments better understood the tools needed to combat the virus. The transience of these measures may also have resulted from the narrative communicated during the pandemic that changes experienced by the public were temporary and would ultimately be reversed and returned to "normal". The temporality of these changes reduced the potential for long-term gains in health and wellness that may have been experienced had these measures been prolonged. The exceptions to this appear to be measures that addressed the affordability of alcohol which were frequently pursued with the intention of either matching inflation or increasing government revenue as part of the economic recovery from COVID-19. The independence of these changes from those made during the pandemic may be an advantage in the long term, allowing governments to maintain relatively high taxation rates on alcohol and tobacco.

SUB-NATIONAL AUTHORITIES MAY BE EFFECTIVE PARTNERS IN CURBING ALCOHOL CONSUMPTION AND TOBACCO USE

4 Although national governments used policy levers related to the acceptability and affordability of alcohol consumption and tobacco use, the 11 countries provided examples of where subnational authorities were effective partners in altering the availability of alcohol and tobacco during the pandemic. This trend was observed in India, Myanmar, Nepal and Thailand, where restrictions on availability – including purchasing on-premises and off-premises differed by state or region. In some countries, such as Thailand, the subnational differences emerged after the initial wave of the pandemic, when measures were linked to local COVID-19 infection rates. Other countries, such as India, appeared to take a subnational role from the outset of the pandemic, especially regarding alcohol. In addition, two countries, India and Indonesia, implemented subnational smoking bans in specific cities. Although sufficient information was available through these case studies to determine at what level policy changes should be made, governments may consider the additional tools available to them at a secondary level.

GOVERNMENTS MAY FEEL INDEBTED TO THE INDUSTRY AFTER THE COVID-19 PANDEMIC

6 The alcohol and tobacco industry played a complex role during the COVID-19 pandemic. There was significant corporate social responsibility by industry in governments' pandemic responses through the donation of money and supplies as well as the repurposing of liquor manufacturing facilities to create hand sanitizers. The acceptance and permission for corporate social responsibility activities are in opposition to recommendations provided in Article 5.3 of the Framework Convention on Tobacco Control, which requires governments to "protect public health policies from commercial and other vested interests of the tobacco industry in accordance with national law"*(46)*.

In addition, national country counterparts reported direct and indirect interference in government decisions related to the pandemic, particularly when affected by official measures concerning restricting the acceptability and availability of alcoholic beverages and tobacco products, such as industry lobbying to designate products as essential commodities throughout lockdowns and bans. This interference may leave governments feeling indebted to industry after the COVID-19 pandemic. Further, countries may need to address the perception developed during the pandemic that industry is a critical and legitimate stakeholder in developing public health policy ■

PREPARATION FOR FUTURE PANDEMIC EVENTS

This section illustrates prospective policy actions for future pandemic events

GUIDANCE RELATED TO ACCEPTABILITY

For alcohol and tobacco

Introduce stronger regulations to protect public health goals over vested interests. This includes ensuring commitment across government to protect public health goals over economic and financial arguments, including over the significant corporate social responsibility activities that occurred during the COVID-19 pandemic. Evidence on, and inspiration for, policy approaches to address and manage vested interests can be found in this WHO Snapshot.

Strengthen policies and regulations around indirect advertising, promotion and sponsorship by the alcohol and tobacco industry, which has expanded throughout the pandemic, particularly on social media platforms *(47)*. Evidence on, and inspiration for, policy approaches to address digital marketing can be found in this WHO Snapshot.

Prioritize early public education related to the stigmatization of communicable diseases and publicize widely the correlations between alcohol consumption, tobacco use and increased risks of communicable and noncommunicable diseases to help combat medium- to long-term effects of the pandemic *(48)*. Additional research could help develop tailored awareness campaigns for at-risk populations.

Tobacco specific

Assess the feasibility of permanently extending temporary measures enacting bans on public smoking and spitting in certain public places in alignment with Article 8 of the Framework Convention on Tobacco Control *(49)*.

GUIDANCE RELATED TO AVAILABILITY

For alcohol and tobacco

Consider the widespread exclusion of alcohol and tobacco from essential commodities lists. In accordance with the South-East Asia Regional Action Plan to implement the Global Strategy on the harmful use of alcohol, this measure should be coupled with an expansion of coverage and options available to support quitting and addressing withdrawals (6). Some individuals have been able to curb their alcohol consumption and tobacco use during the pandemic. However, it has been difficult for others who need support tailored to the pandemic context: i.e. support provided at a greater frequency and accessibility *(47, 49, 50)*. Suggested support from a systematic review includes providing behavioural counselling by telephone or video conference during a pandemic outbreak and, with tobacco specifically, increasing the availability of nicotine replacement therapies. However, additional evidence is required to confirm their effectiveness *(49)*.

Alcohol specific

Amend existing policies and frameworks on the sale of alcohol to contend with new challenges, including online ordering and home delivery. This could also be used to reinforce support provided by social service and housing organizations to address aspects of alcohol harm that increased during lockdowns, such as domestic violence *(51)*.

Monitor the implications to public health and ongoing changes to the availability of alcohol during the pandemic and sustained afterwards, such as the lifting of alcohol import bans in certain countries as these may be difficult to reverse later *(47)*.

GUIDANCE RELATED TO AFFORDABILITY

For alcohol and tobacco

Increase taxes, including excise and import taxes, levied on alcohol and tobacco and avoid implementing industry concessions, such as deferring tax payments *(49)*. Different approaches to reducing the affordability of alcohol and increasing government revenue could include direct levies on the net profits of alcohol and tobacco companies and other pandemic-specific fees ■

TAKEAWAY MESSAGES

1

Measures related to acceptability and availability are easier to implement and frequently under the purview of emergency acts. The primary objective of closing or reducing working hours and modalities of on-premise and off-premise outlets, as well as restrictions on social and family gatherings, was to reduce contact and the spread of COVID-19. These choices had the knock-on effect of reducing the purchasing of alcohol and tobacco.

2

Restrictions in movements adopted during the COVID-19 pandemic resulted in a significant expansion of online ordering and home delivery of alcohol and tobacco products. However, it is unlikely that online sales and home delivery will cease post-pandemic.

3

The temporality of the measures reduced the potential for long-term gains in health and well-being that may have been experienced had these measures been sustained. As changes were made with the primary objective of reducing the spread of COVID-19, they were frequently reversed following the first or second wave – once countries better understood the tools needed to combat the virus.

4

Restricting the affordability of alcoholic beverages and tobacco products via taxation requires changes in legislation challenging to pass under emergency acts. Countries that focused on reducing affordability frequently did so at the import or manufacturing stages, levying import rather than excise taxes. These do not translate to increased prices at the point of consumption.

5

The alcohol and tobacco industries played a complex role during the COVID-19 pandemic. On the one hand, many of these companies supported governments by donating money and supplies and repurposing liquor manufacturing facilities to create hand sanitizers. On the other hand, country counterparts reported direct and indirect interference in decisions related to the pandemic, particularly when affected by the measures related to restricting the acceptability and availability of alcoholic beverages and tobacco products.

6

Developing social communication plans to combat misinformation about the protective factors of alcohol and tobacco and raise awareness about the risks of alcohol consumption and tobacco use more generally and their links to communicable and noncommunicable diseases.

7

Subnational authorities may be effective partners in curbing alcohol consumption and tobacco use.

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COVID-19 has caused severe social and economic disruptions and taken an incalculable toll on human health. The adoption of public health measures, including travel restrictions, physical distancing, and stay-at-home directives, has significantly changed how goods are produced, purchased, and consumed, including unhealthy commodities such as alcohol and tobacco. Throughout the pandemic, changes in the consumption of alcohol and tobacco have been observed, coupled with the increased likelihood of severe infections of COVID-19 among those who consume alcohol and use tobacco. In response, and to contend with these changes, countries have implemented a range of policy approaches affecting the acceptability, availability and affordability of alcohol and tobacco. In the face of future public health emergencies, this brief suggests actions such as countries introducing stronger regulations to protect public health goals over vested interests; the exclusion of alcohol and tobacco from essential commodities lists; the expansion of services to support quitting and withdrawal; an increase in taxes levied on alcohol and tobacco; and the avoidance of implementing industry concessions, such as deferment of tax payments.

Less alcohol
- More taxes
- Less availability
- No advertising

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