World Health Organization

POLICY, SYSTEM AND PRACTICE RESPONSE TO ALCOHOL CONSUMPTION DURING THE COVID-19 PANDEMIC IN SEVEN COUNTRIES OF THE WHO AFRICAN REGION

BRIEF ❾, OCTOBER 2022

SNAPSHOT SERIES ON ALCOHOL CONTROL POLICIES AND PRACTICE

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(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.

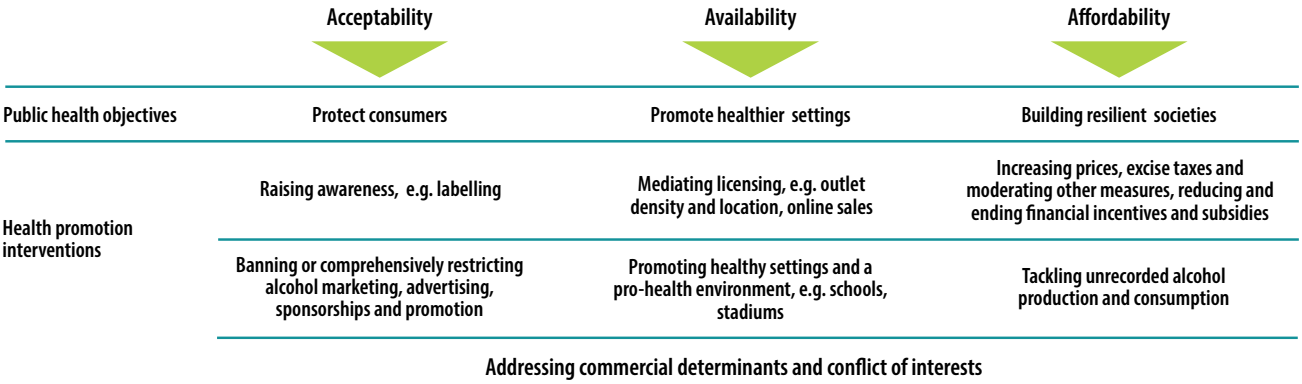
How was this brief developed?

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.

Determinants driving the comsumption of alcohol



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 ■

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BRIEF AT-A-GLANCE

The COVID-19 pandemic: implications for alcohol consumption

As of October 2022, there had been 9.3 million cumulative cases of COVID-19 and 174 566 fatalities reported in the WHO African Region. Though the initial wave of the pandemic was delayed in the continent compared to other global hotspots, the third and fourth waves have been particularly severe in Africa. This has been compounded by an ongoing struggle for vaccine equity, a depression in the African economy, and a range of humanitarian crises, including food shortages and extreme weather events across the continent that have hindered governments' endeavours from responding to the pandemic adequately.

A conceptual framework to approach the policy, system and practice challenges

This Snapshot describes and synthesizes the policy changes in alcohol policies, systems and practices adopted by seven African countries in response to the COVID-19 pandemic. The study focused on seven countries – Botswana, Eswatini, Kenya, Lesotho, Namibia, South Africa and Zimbabwe. The study period was from 1 January 2020 to 30 June 2021. However, the information was updated during the validation process from May to July 2022.

Synthesis of policy, system and practice measures adopted during the COVID-19 pandemic

The policy measures implemented to restrict alcohol consumption included raising awareness about the harmful effects of alcohol consumption and restricting advertising. Many governments enacted public health restrictions – such as changing business hours, closing bars and restaurants and issuing stay-at-home orders. In addition, many governments restricted the availability of alcoholic beverages by suspending or limiting the number of participants in social gatherings due to the increased risks of contracting and spreading COVID-19. All seven countries implemented policy and regulatory changes that altered the availability of alcohol, with the most common measures including restricting on- and off-premises sales and limiting sales hours. Very few countries implemented measures to reduce the affordability of alcohol. Most countries that had policy restrictions on the sale of alcohol did not have clear measures on alcohol taxation. Six of the seven countries reported corporate social responsibility activities being undertaken by the alcohol industry. These activities included donations of public health resources such as sanitizer, face masks and personal protective equipment, as well as monetary donations to support government responses. In addition, the industry engaged in lobbying efforts against government restrictions, misinformation campaigns targeted at undermining evidence of the health risks associated with alcohol consumption and litigation against government decisions.

Lessons learned from the COVID-19 pandemic

The lessons learned include the following: very few efforts to curb the consumption of alcohol have been extended beyond the initial waves of the pandemic; measures to address the availability of alcohol were intertwined with public health measures; many countries experienced an increase in the illicit alcohol trade of alcohol; relatively loose restrictions resulted in an expansion of online and home delivery; and civil society organizations stepped up to support alcohol control during the COVID-19 pandemic ■

THE COVID-19 PANDEMIC: IMPLICATIONS FOR ALCOHOL CONSUMPTION

This section provides an overview of changes to alcohol policy measures and their impact on acceptability, availability and affordability during the COVID-19 pandemic

COVID-19 context

On 11 March 2020, WHO 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, with respect to morbidity and mortality from the virus, and indirect, through strained health and social systems and the depression of global economies – for example, it is estimated that the COVID-19 pandemic has pushed an additional 97 million people into extreme poverty *(2)*.

The adoption of public health measures – including travel restrictions, physical distancing and stay-at-home directives – has significantly changed the ways in which goods are produced, purchased and consumed, including unhealthy commodities such as alcoholic beverages. Though the measures were necessary to control COVID-19 infections, without the necessary safeguards, many of these measures resulted in significant changes to the consumption of alcohol and its associated risks. For example, stay-at-home directives shifted consumption from on-premises to at-home, and the closures of bars and restaurants resulted in increased off-premises sales through e-commerce and retail shops. In addition, during the pandemic, a lack of attention was put into designing and managing policies that promote healthy behaviours, including limiting alcohol consumption. The COVID-19 pandemic inflicted exceptionally high morbidity and mortality rates on those already vulnerable, compounding the health, social and economic challenges associated with alcohol consumption *(3)*.

The WHO African Region

The WHO African Region comprises 47 member states and accounts for 17% of the world's population *(4)*. The Region comprises diverse countries and abundant resources, including young people with great potential to support inclusive growth across the continent. However, the COVID-19 pandemic has resulted in a significant set-back in earlier health and social gains. As of October 2022, there have been 9.3 million cumulative cases of COVID-19 and 174 566 fatalities reported in the WHO African Region *(4)*. Though the initial wave of the pandemic was delayed in the continent compared to other global hotspots, the third and fourth waves of the pandemic have been particularly severe. This has been compounded by an ongoing struggle for vaccine equity, a depression in the economy, a range of humanitarian crises, including food shortages in 38 of the 47 countries and extreme weather events that have hindered governments' efforts to respond to the pandemic adequately (5). Further, disruptions in global supply chains have resulted in a shortage of medical supplies placing additional strain on already overburdened health systems.

In this vast and diverse continent, the seven countries of this study show the highest consumption rates of alcohol consumption per capita in the WHO African Region *(6)*. They also share a high proportion of heavy drinking episodes in those aged 15–19 years *(7)*. In addition, the illicit traffic of alcohol across and between these countries and the widespread tradition of home-brew alcoholic beverages represent significant challenges for governments in controlling alcohol consumption *(8)*. This brief illustrates policies, systems and practices pursued in response to the COVID-19 pandemic to control alcohol consumption in these seven countries.

Alcohol and the COVID-19 pandemic

Alcohol consumption is a risk factor for the development of major noncommunicable and communicable diseases, premature mortality, injury and domestic violence, all of which have severe economic and societal costs *(9)*. 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 (SARS) *(10, 11)*. In addition, many of the conditions associated with alcohol consumption increase the risk of complications and death following a COVID-19 infection. For example, mortality from COVID-19 among hospitalized patients with liver cirrhosis was twice as likely as among those without *(12)*. Similarly, studies have shown the mortality rate of COVID-19 patients with cancer – a known condition resulting from alcohol consumption – was higher than for those without *(13)*. Since alcohol has both long- and short-term effects on the body, there is no safe limit to consumption.

The fear of COVID-19 infection, uncertainties about the future, isolation, loneliness and social disruptions have significantly influenced global mental health *(14)*. The COVID-19 pandemic is estimated to have caused a 27.6% rise in cases of major depressive disorder and a 25.6% increase in cases of anxiety disorder worldwide, with low- and middle-income countries bearing the brunt of the burden *(15)*. Evidence suggests that heavy alcohol consumption may increase during challenging times, such as crises and pandemics *(16-18)*. 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 *(19-21)*. Countries in Africa have not been immune to this trend. A survey on alcohol consumption in South Africa noted that in July–November 2020, nearly 50% of participants self-reported consuming alcohol in a manner that fell into the heavy-episodic drinking category, with the majority having purchased alcohol illegally while COVID-19 restrictions were in place *(14)*.

Furthermore, alcohol consumption is a known contributing factor to socioeconomic differences in mortality. For example, a study conducted in South Africa found that in 2015, 60% of alcohol-attributable deaths occurred in people in low socioeconomic groups, compared to 15% in higher socioeconomic groups *(22)*.

The COVID-19 pandemic has impacted alcohol consumption. Many efforts are ongoing to estimate the negative ramifications of these changes for population health and well-being. However, the long-term effects are still unknown and require governments to be equipped with new and innovative policy, system and practice responses ■

A CONCEPTUAL FRAMEWORK TO APPROACH THE POLICY, SYSTEM AND PRACTICE CHALLENGES

This section provides a description of the approach used to identify, analyze and synthesize changes in the policy, system and practice measures adopted by countries

Scope of the study

This study aimed to describe and synthesize the changes in alcohol policies, systems and practices adopted by selected countries in response to the COVID-19 pandemic. The study focused on seven countries – Botswana, Eswatini, Kenya, Lesotho, Namibia, South Africa and Zimbabwe. The period of the study was from 1 January 2020 to 30 June 2021. However, information was updated during the validation process from May to July 2022.

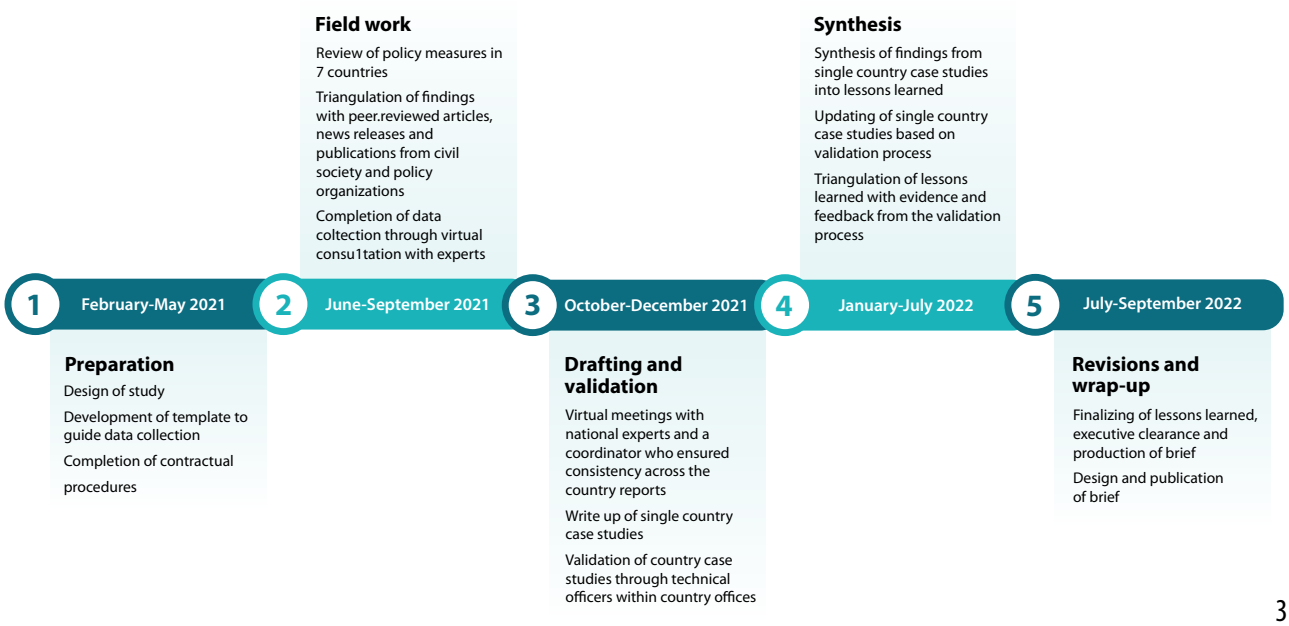
Conceptual framework

Addressing the multidimensional connotations of drinking alcohol requires a portfolio of population-wide interventions. Changes in policy frameworks guided by public health objectives are expected to moderate the determinants driving the acceptability, availability and affordability of these unhealthy commodities. During the COVID-19 pandemic, for example, public health objectives to protect people's health led to the implementation of emergency measures to raise awareness about the harmful effects of alcohol consumption, 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 19 variables for alcohol policy interventions was identified based on previous work, including the Global strategy to reduce the harmful use of alcohol *(24)* and the snapshot series on alcohol control policies and practices *(8, 23)*. Each variable represents a policy tool related to the acceptability, availability or affordability of alcohol. 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.

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



Sources of data and collection

The study is based on a scoping review of publicly available policy, legal and regulatory documents published between 1 January 2020 and 30 June 2021. The desk review used various online sources, including official government websites and press releases, as well as associated social media accounts. The search focused on national and subnational legislation and bylaws – such as regulations, rules, administrative action notifications, decrees, judicial rulings and official press releases. In addition, other sources were used to complement and cross-check the information, including peer-reviewed articles, media news, civil society publications and outputs from reliable policy organizations. Different sources were used to triangulate the information, including a desk review of publications and blogs published by civil society organizations. A search of the relevant legal and policy documents on the COVID-19 Law Lab *(24)* was also conducted using the pre-defined categories of "movement & distancing restrictions" and "state of emergency/public health emergency".

Structure of the template

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

Management of the experts and national counterparts

Countries participating in the scoping review appointed national experts. The study's scope, objectives and template were discussed with each group of national counterparts. 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. Virtual meetings served to streamline the drafting process, address common challenges faced during the data collection and identify lessons learned for each country.

Validation process

A first validation step was undertaken by the technical officers in charge of alcohol 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 instruction note was shared with each national counterpart to streamline the validation. The instruction note sought the support of the national counterparts for alcohol 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 it; those unrelated to the pandemic; and those adopted to protect public health or to accelerate economic recovery. Finally, the instruction note requested that information related to measures that were applied after the period of study (i.e. from 1 January 2020 to 30 June 2021) be updated to 30 July 2022. The WHO country offices facilitated the follow-up process. The feedback was incorporated into a new draft of the study findings.

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 driving alcohol consumption (Table 1). Additional measures were also included, e.g. the analysis of corporate social responsibility activities undertaken by industry during the initial waves of the COVID-19 pandemic.

The findings across countries were analyzed by national experts, including WHO officials, to draw lessons learned. Experts included those with country and global-level experience in regulating commodities and preventing noncommunicable and communicable diseases.

Development of the lessons learned

Lessons learned were initially developed based on four inputs: 1) trends in the policy, system and practice measures implemented in each of the seven countries; 2) a literature review of synthesized evidence published during the pandemic relating to each of the variables; 3) any evaluation identified during the validation process, and 4) inputs from the desk review on civil society organizations.

Table 1. Overview of measures adopted

Acceptability	Availability	Affordability
Ban on consumption	Restricting imports	Increasing import taxes
Essential commodity status	Restricting manufacture	Increasing VAT
Restricting use	Restricting on-premise sales (e.g. hotels, bars and restaurants)	Increasing excise tax – national
Raising awareness about the harmful effects of alcohol consumption	Restricting off-premise sales (e.g. liquor and convenience stores, supermarkets, number of retailers)	Increasing excise tax – subnational
Restricting advertisements	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	

These lessons adopted public health and population-wide perspectives to protect health by addressing the acceptability, availability and affordability driving alcohol consumption.

Once drafted, national counterparts were sent a complete draft of the report and offered the opportunity to weigh in on the lessons learned. National counterparts were asked to provide informed perspectives to ensure the lessons resonated with their experience. This process served to refine further the lessons learned based on their input.

WHO quality assurance process

WHO has a three-step internal clearance process for publications. The Publications Review Committee oversees and provides clearance for all documents related to public health emergencies, including the COVID-19 pandemic. The decision of the Committee is made at the planning and executive clearance stages to ensure relevance, consistency, methodological validity, and compliance with quality standards. Approval for publication by the Committee was provided on 18 October 2022.

Management of conflicts of interest

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

Limitations of this study

The study applies a scoping review of publicly available documents. The analysis scopes, maps and characterizes policy, system and practice changes but does not address the factors underpinning the political choices nor whether the policy objectives were achieved following the implementation of the regulatory changes.

In addition, the 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 impossible to collect the data retrospectively; thus, information from these seven countries on what occurred after the initial waves of the pandemic is incomplete.

Another limitation is the lack of systematic evaluations of the effects of the changes that countries implemented. Throughout much of the brief, there is an implicit assumption that measures that reduce the acceptability, availability and affordability of alcohol 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 ■

OVERVIEW OF REGULATORY INSTRUMENTS ADOPTED DURING THE COVID-19 PANDEMIC

This section provides an overview of the policy and regulatory instruments and enactments adopted by each country to control the acceptability, availability and affordability of alcohol during the COVID-19 pandemic

Botswana

On 20 March 2020, before cases of COVID-19 were reported in Botswana, the government imposed preventive measures, including a ban on entry for people travelling from high-risk countries, a ban on public gatherings of more than ten people and restrictions on restaurant and shop hours of operation *(25)*. On 2 April 2020, the President declared a state of emergency, which was later extended into May 2020 *(25)*. The President also issued emergency COVID-19 regulations that, among other things, declared a lockdown, placed restrictions on movement and assembly, implemented social distancing measures and mandatory quarantine, imposed travel restrictions, closed schools and liquor stores, restricted restaurants to takeaway services and suspended liquor licenses during the state of public emergency *(26)*. Violations of the regulations were subject to various fines, terms of imprisonment or both *(27)*. Later, the government imposed area-specific lockdowns based on reported COVID-19 cases *(27)*.

Eswatini

Eswatini announced its first COVID-19 case on 13 March 2020 *(28)*. A national emergency was subsequently declared a few days later on 17 March *(29)*. The public health and social measures undertaken included closures of schools and non-essential businesses, travel restrictions, mandatory self-isolation, curfews, restrictions on assembly, price-control measures and a nationwide lockdown targeting selected sectors of the economy *(30, 31)*. Restrictions were established based on the disease transmission risk *(32)* and a disaster management task force was appointed *(30, 31)*. The 2006 Disaster Management Act was the primary legislative basis for regulatory measures and national disaster management *(29, 33)*.

Kenya

Kenya confirmed its first COVID-19 case on 12 March 2020 *(34)*. In response, measures on movement and assembly, school closures, travel restrictions, a curfew, mandatory quarantine and stay-at-home orders were imposed. The 1986 Public Health Act *(35)* and the 1950 Public Order Act *(36)* were the primary pieces of legislation used in response to the COVID-19 outbreak.

Lesotho

A state of emergency was declared on 18 March 2020 *(37)* and extended until 30 October 2021 *(38)*. COVID-19 regulations included a country-wide lockdown from 29 March to 21 April 2020, later extended to 5 May. The government imposed movement and assembly restrictions, social distancing measures, mandatory quarantine, travel restrictions, the closure of all non-essential establishments and a total ban on liquor sale, distribution and transportation *(39)*. Violations of the regulations were subject to various fines, terms of imprisonment or both *(39)*. Inspections took place in certain regions to ensure compliance with alcohol sale restrictions *(40)*. The response was adapted according to the COVID-19 infection rates. The National COVID-19 Secretariat was established to coordinate and implement the COVID-19 response strategy and related measures, including developing a Risk Determination and Mitigation Framework *(41)*.

Namibia

Namibia reported the first cases of COVID-19 on 13 March 2020 *(42)* and a state of emergency was declared on 17 March *(43, 44)*. In response, various measures were introduced to address the COVID-19 outbreak, including closures of schools and businesses, restrictions on

public gatherings, mandatory quarantine, restrictions on domestic travel, lockdowns and curfews, restrictions on entry into the country and compulsory mask-wearing. Regulations were issued, repealed, or amended following each phase of the pandemic. Article 26(1) of the Constitution *(45)*, the 2012 Disaster Risk Management Act *(46)* and the 2015 Public and Environmental Health Act *(47)* were the main legislative frameworks used during the COVID-19 response. Regulations banned the sale of alcohol, particularly in bottle stores, bars and other on-premises alcohol outlets, leaving only supermarkets to sell alcohol during the lockdown *(48, 49)*.

South Africa

In March 2020, a state of disaster was declared and public health measures such as restaurant closures and COVID-19 testing started to be implemented *(50)*. After the first COVID-19 case, a national lockdown was announced from 27 March to 19 May 2020 *(51)*. An alert level system was also implemented during the COVID-19 pandemic waves. South Africa has been hit by four COVID-19 waves, each driven by different virus variants. The public health measures adopted during the lockdown included prohibiting public gatherings, introducing mandatory testing, isolation and quarantine; criminalizing the deliberate transmission of COVID-19, and suspending most economic activity outside of essential services *(52)*. The legal framework for responding to COVID-19 was based on the 2002 Disaster Management Act *(50, 52)*. The decision to use the 2002 Act instead of declaring a state of emergency ensured that constitutional rights were not suspended during the state of disaster *(53)*.

Zimbabwe

Zimbabwe reported its first case of COVID-19 on 21 March 2020 *(54)*. A 21-day nationwide lockdown beginning 30 March 2020 *(55)* was adopted via Statutory Instrument 77 of 2020 *(56),* subject to review every two weeks. The lockdown included restrictions on movement and assembly, closure of schools, travel restrictions, curfew, mandatory quarantine and stay-at-home orders. During the lockdown, all non-essential businesses were closed *(56)*. A national disaster was also declared, which could be extended, curtailed or terminated by the President under the 1989 Civil Protection Act *(57)*. A series of statutory instruments to respond to the COVID-19 pandemic were passed under the 2018 Public Health Act (Chapter 15:09) *(58)* ■

SYNTHESIS OF POLICY, SYSTEM AND PRACTICE MEASURES ADOPTED DURING THE COVID-19 PANDEMIC

This section provides an overview of the scoped policy, system and practice measures taken by countries to tackle the acceptability, availability and affordability of alcohol during the COVID-19 pandemic

Tackling the acceptability of alcohol

Four countries implemented regulatory measures that addressed the acceptability of alcohol. Most of this focused on restricting consumption, raising awareness about the harmful effects of alcohol consumption or restricting advertising. Details on the regulatory measures enacted are set out below.

Restricting consumption

Four countries – Botswana, Eswatini, Kenya and Lesotho – introduced new regulations during the pandemic that prohibited the public consumption of alcohol, mainly beer and liquor. In Botswana, restrictions on consumption were also imposed at the subnational level in the Greater Gaborone Zone, which hosts the capital city Gaborone. In Kenya, the rules required that alcoholic beverages were not sold to sit-in customers at restaurants or other entertainment spots and that there was no consumption in public places *(59)*. In some countries, such as Lesotho, additional specifications were included in consumption regulations to cover private events such as social gatherings, weddings and political events. Namibia has prohibited the consumption of alcohol in public places since the passing of the 1998 Liquor Act. During the pandemic, these restrictions were extended to quarantine facilities, where the consumption of liquor, drugs, or other addictive was prohibited *(60)*.

Essential commodity status

Kenya was the only country that designated alcohol as an essential commodity *(59)*. However, in many countries, even without the designation, it remained relatively easy to access alcohol, including to the extent that civil society organizations in some countries, such as Zimbabwe, reported that they thought alcohol had been provided with an essential commodity status. That said, one country, Botswana, undertook significant efforts to reduce alcohol consumption during the pandemic. This included the complete suspension of the sale of alcohol, citing the possibility that alcohol consumption would compound the risk of COVID-19 transmission.

Raising awareness about the harmful effects of alcohol consumption

Three countries – Eswatini, Kenya and Namibia – launched awareness campaigns highlighting the risks of consuming alcohol. In Eswatini, while announcing alcohol restrictions, the government emphasized the harm related to alcohol consumption, such as weakened immune systems, a reduced capability to cope with infectious diseases and the negative association between alcohol consumption and COVID-19 infection. In Kenya, although the National Authority for the Campaign against Alcohol and Drug Abuse initially suspended advocacy and forums on the harm of alcohol and drug use, targeted public awareness campaigns were conducted through mass media to discourage gatherings and prevent the violation of social distancing measures *(61)*. In July 2020, this National Authority issued strong warnings about at-home consumption of alcohol in response to increased online sales and home deliveries of alcohol during the COVID-19 restrictions, including the increased risk of children and young people engaging in underage drinking *(62)*. The National Authority urged parents to create an alcohol-free home environment and safeguard school children staying at home due to COVID-19 movement restrictions. Namibia used an embedded approach to raising awareness, whereby the risks of alcohol consumption and their additional effects on COVID-19 (i.e. weakened immunity, increased likelihood of severe illness) were incorporated in national COVID-19 messaging.

Civil society organizations filled gaps despite significant government efforts in many countries. For example, in Lesotho, the Southern African Alcohol Policy Alliance conducted a campaign entitled "New norm", which drew attention to the harm caused by alcohol consumption before and during the restrictions and advocated for them to be maintained over the long term.

Restricting advertisements

Botswana was the only country out of the seven to implement regulatory measures that affected advertisements of alcohol. While restrictions were initially placed on the advertising of alcoholic beverages, in June 2020, the pre-COVID-19 ban on alcohol sponsorships and advertising in sports was lifted *(63)* since the Ministry of Youth Empowerment, Sport and Culture Development had already allowed sports codes to permit sponsorship from the alcohol industry *(64)*. However, the sale and consumption of alcohol at sporting events remained prohibited *(65)*.

Tackling the availability of alcohol

Enacting and enforcing restrictions on the physical availability of retail alcohol is one of WHO's best buys for cost-effective public health interventions. The COVID-19 pandemic resulted in many governments enacting public health restrictions such as changing business hours, closing bars and restaurants, and issuing stay-at-home orders that restricted de-facto the availability of alcohol. Governments from all seven countries implemented regulatory changes that altered the availability of alcohol, with the most common measures including restricting on- and off-premises sales and limiting sales hours. In addition, many countries undertook measures to tackle the increased risks of contracting and spreading COVID-19 through social gatherings. Details on the regulatory measures enacted are set out below.

Restricting imports

Only one country, Namibia, made regulatory changes that affected the import and export of alcohol. A four-stage emergency approach was adopted with varying degrees of lockdown measures based on the prevailing epidemiological situation. In stages 1 and 2, which lasted from March 2020 until May 2020, the sale and purchase of alcohol were prohibited. However, an exception was made for alcohol sales and purchases for export or temporary importing for re-export *(60)*.

Restricting manufacturing

Two countries, Eswatini and South Africa, implemented regulations that temporarily restricted the manufacture of alcohol *(66)*. In April 2020, Eswatini imposed a nationwide ban on the production, distribution and sale of alcohol based on the elevated risk of contracting and spreading COVID-19 during the consumption of alcohol *(67)*. Following an initial lifting in July 2020, the ban was re-imposed on the assumption that alcohol consumption was one of the drivers contributing to the spread of COVID-19 *(68)*. In October 2020, the ban was lifted following consultations with industry, relevant associations and community organizations*(69)*.

In South Africa, following the decision that the alcohol industry was not considered an essential service, the government announced limitations on the sale, distribution and transportation of liquor. Consequently, the entire production chain related to alcohol manufacturing was shut down from March 2020 until July 2020, when the economy reopened.

Restricting on- and off-premises sales

All seven countries restricted on- and off-premises sales during the initial waves of the pandemic. In all countries, these efforts were linked to broader public health restrictions that limited business operations. Restrictions on on-premises sales were typically maintained for long periods, often lasting from March until August or September 2020. Off-premises sales were usually reinstated relatively quickly, within a month or two. However, the easing of off-premises bans was sometimes accompanied by limitations on social gatherings such as parties or weddings.

Similarly, many countries used a phased approach to return to on-premises sales. For example, in Botswana, when the on-premises sale ban was lifted in June 2020 – following a complete suspension of the sale of alcohol – licensed establishments were allowed to sell alcohol for takeaway, provided that all alcohol was consumed at home *(70)*. Takeaway sales for at-home consumption were initially limited to 10:00–18:00 on Wednesday–Friday and 10:00–16:00 on Saturday. These hours were later tailored to specific days and times and required that the licensee complies with the Director of Health Services' guidelines on preventing COVID-19 transmission.

In Kenya, the off-premises retail sale of alcoholic beverages continued to be permitted through supermarkets, online platforms and alcohol retail stores *(59)*. Workers in the alcohol industry were assigned special permits exempting them from movement restrictions.

Limiting hours of sale

Five of the seven countries reduced the hours permitted to sell alcohol. Reduced hours were often in force during

significant pandemic waves and when alcohol was expected to be consumed; for example, many countries reduced sales on weekends and holidays. In Namibia, for instance, following the removal of the initial alcohol ban, the sale of alcohol on- and off-premises was restricted to specific days and times *(71)*. From June to August 2020, the sale and purchase of liquor for off-premises consumption could only take place at 12:00–18:00 on Mondays to Fridays and 09:00–13:00 on Saturdays *(71)*. Purchase and sale were not permitted on Sundays or public holidays. Similar approaches were used in other countries, demonstrating an understanding by many governments of the link between alcohol consumption and COVID-19 infections. In some countries, such as South Africa, this regulatory approach returned numerous times as the country dealt with different pandemic waves.

Restricting purchasing

Lesotho and South Africa were the only countries that implemented restrictions on purchasing. In Lesotho, once restrictions on select off-premises sales were lifted, purchases were limited based on the quantity of alcohol. Individuals were only permitted to purchase one case of beverages containing 10% alcohol or less, 3 litres of beverages containing 10–20% alcohol, or 1.5 litres of beverages containing 20% alcohol or higher *(72)*. In January 2021, once the Omicron variant had taken hold in the Region, this regulatory approach was returned, allowing individuals only half a case for 1–10% alcohol content, 6 litres for 11–20% or 1 litre for 21% or higher *(73)*. All restrictions on quantity were removed in October 2021. In South Africa, a different approach was used, and establishments were restricted to selling alcohol to 50 individuals daily *(74)*.

Restricting online sales and home delivery

No countries implemented restrictions against online sales. Similarly, relatively few restrictions were placed on home delivery. In South Africa, alcohol purchased online could only be home delivered after the lift of the various bans. The transportation of alcohol was prohibited during the bans except for specified circumstances, such as the production of hand sanitizer. Nonetheless, the country saw a significant increase in alcohol e-commerce *(75)*.

Tacking the affordability of alcohol

Despite being one of the most effective approaches to curb the consumption of alcohol, very few countries implemented regulatory changes that addressed the affordability of alcohol. Kenya and Lesotho increased the excise tax applied to alcohol; however, neither of these was directly associated with the COVID-19 pandemic. In Kenya, the Revenue Authority increased tax on excisable goods, including alcoholic beverages, in line with the average inflation rate, as stipulated by Section 10 of the 2015 Excise Duty Act *(76)*. While in Lesotho, a 15% tax on alcohol was implemented in line with the minimum excise duty in the South African Customs Union. However, this tax has been under consideration since 2017. In 2021, Lesotho's Parliamentary Economic and Development Cluster Committee recommended that the alcohol levy be implemented over five years and required that all liquor traders be registered, which would significantly increase the revenue brought in by the excise tax. In 2021, South Africa raised the excise duty on alcohol by 8% *(77)*. Most countries that had policy restrictions on the sale of alcohol did not have clear measures on alcohol taxation.

Other measures

Alcohol industry corporate social responsibility activities

During the pandemic, 6 of the 7 countries reported corporate social responsibility activities being undertaken by the alcohol industry. These activities included donations of public health resources such as sanitizer, face masks and personal protective equipment, as well as monetary donations to support government responses. For example, in Kenya, East African Breweries Limited donated KSh 50 million to the COVID-19 Emergency Fund and committed KSh 120 million towards the COVID-19 pandemic response up to May 2020 *(78)*. In many countries, industry advertised these efforts to gain a positive public perception and support for their work. For example, in Uganda, manufacturers of a local spirit, waragi, agreed to convert 7.3 million litres of ethanol into hand sanitizer. In return, the government was expected to waive alcohol taxes.

In addition to the donations, the industry also engaged in lobbying efforts against government restrictions and closures, misinformation campaigns targeted at undermining evidence of the health risks associated with consuming alcohol, and litigation against government decisions. In South Africa, the alcohol industry sought to undermine the evidence about the positive health impact of the alcohol ban by discounting the research and credibility of the authors and by commissioning and funding research to demonstrate the ineffectiveness of the alcohol ban in reducing trauma caseloads *(79)*. In many instances, this also included using sympathetic media outlets to reprint industry press releases or editorials challenging the science guiding government policy.

Further, the alcohol industry in South Africa engaged in litigation about the initial alcohol ban and restrictions, taking the government to court to get the ban and restrictions declared unconstitutional *(80, 81)*. On 20 May 2022, the Western Cape High Court dismissed SAB Miller's application against the temporary alcohol sales bans during COVID-19 in South Africa *(80-82)*. It held that the South African COVID-19 regulations, which prohibited the sale, dispensing and distribution of liquor during 2020, were necessary for assisting and protecting the public and addressing other destructive effects of the COVID-19 pandemic, notably the collapse of the health system. The Court stated that the regulations were the least restrictive means for freeing up hospital facilities and services to people infected with COVID-19, reducing the number of trauma cases due to alcohol consumption presenting at hospitals *(80, 81)*. The regulations were judged to be rationally connected to saving lives and livelihoods and upholding the right to life and the right to adequate health care *(80, 81)*.

In addition, the industry used social media in South Africa to interfere with government policy. This included, among other things, providing social media influencers with scripts to promote their product and setting up vaccination sites with photo opportunities for individuals to take pictures for social media with industry logos in the background.

An overview of the policy measures adopted are provided in Table 2 (*next page*).

Table 2. Overview of policy measures on alcohol 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
Botswana	Restricting consumption	Yes (April 2020–)	Ban on public consumption	Restricting on-premises sales	Yes (April – September 2020)	Following an initial ban on all sales of alcohol, a phased approach was used to lift restrictions, with restaurants permitted first, followed by bars and liquor depots	–	–	–
	Lifting restrictions on advertisement	No (June 2020–)	Lifting of pre-COVID-19 ban on sponsorship and advertising in sports	Restricting off-premises sales	Yes (April–June 2020)	Ban was linked to an upsurge in cross-border illicit alcohol trade	–	–	–
Eswatini	Restricting consumption	Yes (no dates reported)	Pre-existing prohibition on public consumption in urban areas, but was extended to all public consumption	Restricting manufacturing	Yes (April–October 2020)	Production ban was briefly lifted in July 2020 but subsequently re-imposed	–	–	–
	Raising awareness about the harmful effects of alcohol consumption	Yes (no dates reported)	Health messages included in announcements on the restriction of sales	Restricting on-premises sales	Yes (March 2020–)	Restaurant sale was later permitted if served alongside food	–	–	–
	–	–	–	Restricting off-premises sales	Yes (April–October 2020)		–	–	–
	–	–	–	Limiting sales hours	Yes (no dates reported)	Sales were prohibited on weekends and business hours reduced	–	–	–

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
Kenya	Restricting consumption	Yes (no dates reported)	Ban on public consumption	Restricting on-premises sales	Yes (March - August 2020)	Sales were banned at bars and restaurants	–	–	–
	Raising awareness about the harmful effects of alcohol consumption	Yes (July 2020–)	Targeted awareness campaigns, including warnings of increased risk with at-home consumption	Permitting off-premises sales	Yes (no dates reported)	Essential commodity status allowed the sale of alcohol through supermarkets, online platforms and retail stores	Increasing excise tax	No (October 2020–)	Tax increase to account for inflation
	Providing essential commodity status	Yes (no dates reported)	–	Limiting sale hours	Yes (March – September 2020)	Sale hours were limited to 19:00 in March 2020, increasing to 22:00 in September	–	–	–
	–	–	–	Permitting online sale	Yes (no dates reported)	–	–	–	–
	–	–	–	Permitting home delivery	Yes (no dates reported)	–	–	–	–
Lesotho	Restricting consumption	Yes (August 2020–October 2021)	Banning public consumption, including during weddings, social, family and political gatherings	Restricting on-premises sales	Yes (April 2020–)	Closing establishments selling alcohol in April 2020 and prohibiting sale in restaurants in January 2021	Increasing excise tax	No (March 2020–)	Alcohol tax increased to 15%
	–	–	–	Restricting off-premises sales	Yes (April 2020–)	Closing establishments selling alcohol such as liquor stores in April 2020	–	–	–
	–	–	–	Restricting purchasing	Yes (May 2020–)	Purchases were limited based on quantity	–	–	–
Namibia	Restricting consumption	No (1998–)	Pre-existing restrictions on consumption in public places	Permitting alcohol exportation	Yes (no dates reported)	–	–	–	–
	Raising awareness About the harmful effects of alcohol consumption	Yes (no dates reported)	Embedded messaging related to alcohol risks within COVID-19 communications	Restricting on-premises sales	Yes (March–July 2020)	Sales of alcohol in shebeens, bars, pubs and night clubs were banned, with some restrictions on alcohol takeaway	–	–	–
	–	–	–	Restricting off-premises sales	Yes (March 2020–)	Closing of liquor stores	–	–	–
	–	–	–	Limiting sale hours	Yes (June–August 2020)	Sales were restricted on weekdays to 12:00–18:00 and Saturdays to 9:00–13:00	–	–	–

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
	–	–	–	Restricting manufacturing	Yes (March–July 2020)	–	–	–	–
	–	–	–	Restricting on-premises sales	Yes (March, July and December 2020, and May 2021)	–	–	–	–
	–	–	–	Restricting off-premises sales	Yes (March, July and December 2020)	–	–	–	–
South Africa	–	–	–	Limiting sales hours	Yes (June, July and September 2020, and February 2021)	During stay-at-home orders, sale hours were limited to 10:00–17:00 Monday–Thursday in June 2020. In July, the sale was permitted from 9:00–17:00 Monday–Thursday. Sales were permitted on Fridays in September 2020. In February 2021, sales were permitted at 10:00–18:00 Monday–Thursday.	–	–	–
	–	–	–	Restricting purchasing	Yes (no dates provided)	Establishment sales were restricted to 50 people a day	–	–	–
	–	–	–	Restricting home delivery	Yes (no dates provided)	Restrictions were placed on orders during the sales ban	–	–	–
	–	–	–	Restricting on-premises sales	Yes (March–August 2020)	Banning alcohol sales and closing on-premises establishments	–	–	–
Zimbabwe	–	–	–	Restricting off-premises sales	Yes (March–April 2020)	Temporarily restricting sales in supermarkets and retail outlets	–	–	–
	–	–	–	Limiting sales hours	Yes (no dates provided)	Limiting hours of sale in retail to 10:00–16:00	–	–	–
	–	–	–	Permitting online sales	Yes (no dates provided)		–	–	–

*– indicates that no additional regulatory action has been taken

LESSONS LEARNED FROM THE COVID-19 PANDEMIC

This section summarizes lessons emerging from the settings studied in relation to the response measures adopted for addressing the acceptability, availability and affordability driving alcohol consumption during the COVID-19 pandemic

VERY FEW EFFORTS TO CURB THE CONSUMPTION OF ALCOHOL HAVE BEEN EXTENDED BEYOND THE INITIAL WAVES OF THE PANDEMIC

1 In all seven countries, there were examples of strong regulations implemented to curb alcohol consumption. However, in almost all instances, they were not maintained beyond the initial first wave of the COVID-19 pandemic. This is despite evaluations demonstrating the restriction of alcohol availability yielding positive results, including a significant reduction in the burden on the health system and reduced harm caused by alcohol consumption and a reduction in unnatural deaths *(83)*. Some measures could have been maintained; for example, the awareness campaigns focused on the elevated risk of poor outcomes from COVID-19 associated with alcohol consumption. However, many countries faced pressure from the public and the alcohol industry to repeal restrictions during the initial few months of the COVID-19 pandemic.

Following the lifting of initial restrictions, some countries maintained additional restrictive measures. For instance, in Kenya, the National Authority for the Campaign against Alcohol and Drug Abuse partnered with the Kenya Alliance of Resident Associations to continue to raise awareness about the harmful effects of alcohol consumption and run prevention programmes to encourage alcohol-free home environments. In addition, the National Transport and Safety Authority strengthened drink-driving measures by resuming alcohol breathalyzer tests in big towns, permitting police to perform random tests on motorists to determine their blood alcohol levels and strengthening general enforcement measures, such as speed monitoring, lane discipline and compliance with public service vehicle licensing *(84)*.

REGULATIONS TO ADDRESS THE AVAILABILITY OF ALCOHOL ARE INTERTWINED WITH PUBLIC HEALTH MEASURES

2 Many measures implemented were secondary effects of the COVID-19 pandemic regulations rather than deliberate policy choices targeted at reducing alcohol consumption. The primary objective of lockdowns and closures was to limit the spread of COVID-19 rather than reduce alcohol consumption. However, these measures showed positive effects on curbing alcohol consumption and associated risks in the relatively short period regulations were in place. In all countries, regulations on alcohol control reverted to their pre-pandemic status when restrictions on gatherings and physical distancing were removed. The one exception was the sale hours of off-premises retailers, for which some governments took a phased approach. The temporary nature of these measures reduced the potential for long-term health gains that may have been experienced had these measures been prolonged.

DIFFERENT REGULATORY APPROACHES MAY BE NEEDED TO TARGET DIVERSE POPULATIONS

3 Policy and regulatory measures for restricting alcohol consumption provide more sustainable and binding tools than ad-hoc measures to control the acceptability, availability and affordability of alcohol. Public health law can play a critical role in consolidating the substantive, procedural, institutional and enforcement measures for regulating alcohol consumption at the national and subnational levels. The multifaceted nature of public health laws can be utilized to address a spectrum of public health threats and provide options to strengthen pathways to prevent and manage diseases. Only one study demonstrated

that the restrictions imposed during the pandemic to reduce alcohol consumption in South Africa reduce alcohol consumption and harm. Moderate drinkers self-reported a reduction in alcohol intake due to the measures adopted during the pandemic. However, these measures also increased alcohol consumption among heavy episodic drinkers *(14)*. Similar findings were identified in South Africa's Western Cape and may point to the need for different regulations or additional supports to be put in place for diverse populations. This point has been reiterated as one of the key findings from the Lancet Commission on lessons for the future from the COVID-19 pandemic that the public policy failed to adequately address the profoundly unequal effects of the pandemic on different groups *(3)*. Efforts should be focused on establishing support mechanisms to reduce stress and anxiety, which are frequently the reasons for increased drinking among heavy episodic users *(14)*.

MANY COUNTRIES EXPERIENCED AN INCREASE IN THE ILLICIT TRADE OF ALCOHOLIC BEVERAGES

4 Many countries experienced an increase in illicit alcohol trade during the pandemic *(85)*. In the face of widespread restrictions in many countries, alcohol was made available by unregistered vendors or the continued illegal sale from outlets in small quantities. The smuggling of alcohol between borders into certain countries with more restrictions was of particular concern. For example, numerous arrests were made smuggling alcohol from Zimbabwe to South Africa. Similarly, unofficial reports from police in Namibia noted an overwhelming increase in the sale of Angolan beer in Northern Namibia. At the same time, the Zambezi region in the north-east of Namibia saw a steep rise in spirits smuggled from Zambia *(86)*. Illicit trading and price hiking of alcohol also took place in Lesotho, whereby alcohol was sold at twice the regular price in some instances. Illicitly produced and procured alcohol poses additional risks to consumers' health. In fact, there is no quality control over how these products are made, and they can contain ingredients that increase the risk of poisoning.

RELATIVELY LOOSE RESTRICTIONS RESULTED IN AN EXPANSION OF ONLINE AND HOME DELIVERY

5 One of the most concerning trends related to alcohol consumption to have come out of the COVID-19 pandemic is the significant expansion of online sales and home delivery across the seven countries. None of the seven countries took proactive measures to restrict online alcohol purchases or home delivery, though the extent of the expansions varied by country. For example, in Kenya, no specific measures were undertaken for online sales or home delivery of alcoholic beverages during the pandemic, and the restrictions for on-premises sales did not apply to online ordering and home delivery. This led to an unprecedented increase in alcohol consumption at home *(87)*. Online ordering and home delivery increase access to and consumption of alcohol by younger people. This is associated with an increased risk of harm and probability of developing an alcohol use disorder in adulthood *(88)*.

CIVIL SOCIETY ORGANIZATIONS STEPPED UP TO SUPPORT ALCOHOL CONTROL DURING THE COVID-19 PANDEMIC

6 Though many of the measures implemented fell short of reducing alcohol consumption over the long term, civil society organizations and community-led efforts were decisive in creating momentum and accelerating grassroots action to raise public demand for change. Their activities included lobbying, advocacy, pursuing legal actions and demanding the development of awareness campaigns. Examples include the Southern African Alcohol Policy Alliance, which supported the restrictions during the pandemic and lobbied for tighter measures, including a ban on all alcohol advertising, restrictions on promotion and the suspension of liquor licenses for establishments that contravened the rules. In Namibia, civil society organizations lobbied for the draft national alcohol policy to be enacted by the Parliament, which would impose levies on alcohol as a potential alternative income for shebeen owners and provide access to prevention and treatment interventions for alcohol use disorders. Though civil society organizations built opportunities throughout the pandemic to advocate for increased restrictive measures, organizations noted a significant decline in the uptake of their treatment and alcohol harm prevention programmes *(89)* ■

TAKEAWAY MESSAGES

This section provides policy, system and practice takeaway messages to consider for reducing alcohol consumption and its related harm in light of preparing for future pandemic situations in the selected countries

Related to acceptability

- Consider introducing stronger regulations to protect public health goals over vested interests. This includes ensuring government commitment to protect public health goals over economic and financial arguments, for example, avoiding the acceptance of industry support through corporate social responsibility activities.

WHO Snapshot: Addressing and managing conflicts of interest in alcohol control policies *(90)*.

- Strengthen policies restricting advertising, promotion and sponsorship of alcoholic beverages. This includes re-imposing bans on sponsorship, removed during the COVID-19 pandemic in some countries, and developing strategies to contend with new challenges such as digital marketing.
- Invest in research that assesses the policy and regulatory measures implemented throughout and following the pandemic to design more effective interventions and change behaviours to reduce alcohol consumption in future pandemics.
- Support the continued efforts of civil society organizations working to change norms related to alcohol consumption, provide support for the prevention and management of addictions, develop campaigns against alcohol advertising and challenge industry practices.

Related to availability

- Consider revisiting decisions made to declare alcoholic beverages an essential commodity and the industry a necessary service during future public health emergencies. Instead, consider increasing the support for heavy drinkers, those who experience harm and those who increase alcohol consumption as a coping mechanism during stress by expanding access to behavioural counselling provided via telephone or video conferencing.
- Amend existing regulatory frameworks on the sale and distribution of alcohol to contend with new challenges, such as online sales and home delivery, which have significantly expanded during the pandemic.
- Design and implement measures to ensure illegal alcohol smuggling and sales do not persist or worsen during public health emergencies. This includes a particular focus on addressing the cross-border illicit alcohol trade, which was particularly prevalent during the pandemic.

WHO Snapshot: Unrecorded alcohol: what the evidence tells us *(91)*.

Related to affordability

- Revisit fiscal policy and, possibly, earmark funds from taxes to finance interventions for alcohol control

WHO Snapshot: 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 *(92)*.

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This Snapshot describes and synthesizes the policy changes in alcohol policies, systems and practices adopted by seven African countries in response to the COVID-19 pandemic: Botswana, Eswatini, Kenya, Lesotho, Namibia, South Africa and Zimbabwe. Measures implemented to address the acceptability of alcohol focused on restricting consumption, raising awareness or restricting advertising. Many governments enacted public health restrictions such as changing business hours, closing bars and restaurants and issuing stay-at-home orders that restricted the availability of alcohol. Very few countries implemented regulatory changes that address the affordability of alcohol. Six of the seven countries reported corporate social responsibility activities being undertaken by the alcohol industry and lobbying efforts against government measures. Few efforts to curb the consumption of alcohol have been extended beyond the initial wave of the COVID-19 pandemic. Many countries saw an increase in the illicit trade of alcohol; relatively loose restrictions resulted in an expansion of online and home delivery. Civil society organisations stepped-up to support alcohol control.

Less Alcohol Unit
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