World Health Organization

Restricting alcohol availability in practice Evidence from selected countries

Brief 14

Snapshot series on alcohol control policies and practice

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(Snapshot series on alcohol control policies and practice)

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Contents

About the series

In 2022 – more than a decade after adopting the World Health Organization (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. A global action plan for 2022–2030 aims to leverage the available evidence and policy know-how to 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.

In 2021, WHO launched a series of advocacy and policy briefs about blind spots serving as a compass for navigating critical topics related to the high-impact and innovative interventions to accelerate progress in reducing alcohol consumption. The resulting topic-specific briefs were considered starting-points for navigating the evidence and its use in practice, forming the edition of the Snapshot Series. They provide a portfolio of policy, system and practice guidance for tackling the determinants driving the acceptability, availability and affordability of alcohol consumption.

The topics covered include conflicts of interest, labelling, licensing, unrecorded alcohol, digital marketing, per capita alcohol consumption, no- and low-alcohol beverages, alcogenic settings and adolescents, gender-responsive policies, environment and policy options to respond to emergencies and pandemic situations.

How was this brief developed?

The 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 synthesized in a brief report that forms the varied issues of the snapshots.

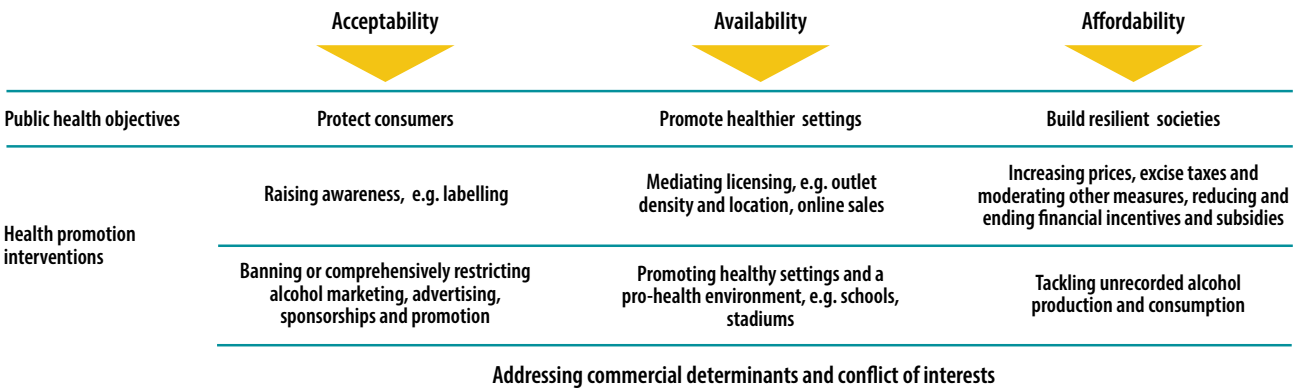
Audience

The series is intended for a wide audience, including people working in public health and those working in local and national alcohol 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 policies, research and practice.

What is a health promotion approach to reducing alcohol consumption?

Evidence demonstrates that cultural, social and religious norms influence alcohol consumption as well as its normalization (acceptability), ease of purchase (availability) and price (affordability). Tackling upstream the determinants driving alcohol consumption requires a portfolio of policy measures that address these multidimensional aspects with population-based interventions that have been proven to be effective ■

Determinants driving the consumption of alcohol



Interested in other topics?

Visit the Less Alcohol webpage for other briefs in this series and forthcoming webinars. Subscribe to our 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. ■

Acknowledgements

Contributors

- Pamela Trangenstein, Alcohol Research Group, the United States of America
- Juan Tello, World Health Organization

Contributors to the research

- Raimee Eck, Johns Hopkins Bloomberg School of Public Health, United States of America
- Patrick Tiongson, Boston University School of Public Health, United States of America
- Jih-Cheng Yeh, Boston University School of Public Health, United States of America

Contributors to case studies

- David Jernigan, Boston University School of Public Health, United States of America
- Egide Haragirimana, Centre for Health Policy Analysis and Research, Burundi
- Orratai Waleewong, Ministry of Public Health, Thailand
- Niamh Fitzgerald, Stirling University, United Kingdom of Great Britain and Northern Ireland
- Isabelle Uny, Stirling University, United Kingdom of Great Britain and Northern Ireland
- Nazarious Mbona Tumwesigye, Makerere School of Public Health, Uganda
- Benjamin Kaneka, University of Malawi, Malawi

Reviewers

- David Jernigan, Boston University School of Public Health, United States of America
- Dag Rekve, World Health Organization

Brief at a glance

The problem: restricting the availability of alcohol

Alcoholic beverages contain ethanol, an established psychoactive and toxic substance that can cause dependence and is associated with public health challenges. Harm caused by alcohol consumption may extend beyond individual drinkers, affecting families and communities through increased rates of violence, road crash injuries and health-care expenditure. Policy measures that restrict alcohol availability have proven to be effective at reducing alcohol consumption, shaping consumption patterns and mitigating harm. However, the implementation and enforcement of these policy measures varies across countries, limiting their impact. Country evidence and data on the specific measures applied remain sparse and prevent global guidance.

The evidence: country policy measures to restrict alcohol availability

Analysis of a selection of 30 countries with licensing systems showed that the most common feature was categorizing the types of outlets and alcohol sold. Countries prohibit alcohol sales at some locations, commonly at educational premises, health facilities, houses of worship and sport sites. Fewer countries establish a minimum required distance between alcohol outlets and sensitive locations, such as alcohol treatment centres and houses of worship. Required distances ranged between 100 and 500 metres. Only a few countries have an alcohol outlet density policy that establishes a population quota with varying thresholds of one outlet for every 300, 450, 600 or 1000 inhabitants. Only one third of countries regulated the days of sale, and more than half restrict the hours of sale. Licensing renewals are commonly set at one-year intervals, with 40% of countries including instructions for communities on how to protest during the application and renewal phase. The most common minimum legal purchase age is 18 years. Remote sale and delivery of alcohol is largely unregulated. Only a few countries require age verification at the point of sale or delivery. Fines are the most common implemented penalty. Other penalties include administrative points and suspending or cancelling the licence and reducing hours.

The know-how: country case studies

Policy measures that restrict the availability of alcohol can be used to address public health concerns in specific contexts. Botswana applied minimum distance standards to address young people's alcohol consumption, including its effects on HIV transmission, disease progression and reduced medication adherence. Burundi regulated availability to tackle the high prevalence of alcohol use, also among pregnant women. Malawi and Uganda banned alcohol sachets to address early initiation to alcohol consumption. Alcohol-related mortality declined in Lithuania after the introduction of a series of policy measures including stricter regulations on alcohol outlet density and hours of sale. Thailand pioneered a ban on alcohol delivery to reduce alcohol consumption among young people. Viet Nam banned the consumption and sale of alcohol near sensitive facilities to tackle a dramatic rise on per capita alcohol consumption.

The way forward

A coordinated, multisectoral approach is needed to address the challenges of restricting alcohol availability. Governments should focus on adopting clear and enforceable policy measures tailored to their unique social, cultural and economic contexts with an emphasis on limiting the proliferation of alcohol outlets and addressing unregulated markets. Engaging civil society organizations and community leaders in developing and implementing policy can enhance public support and compliance. In addition, fostering international knowledge exchange and investing in policy-relevant research will provide the tools necessary to bridge evidence gaps and inform global alcohol policy efforts ■

The problem: restricting the availability of alcohol

Alcohol is a psychoactive substance with intoxicating and dependence-producing properties. Its consumption is causally associated with inherent health risks and injuries. Alcohol harm extends to multiple sectors, including the health, safety, security, social and economic sectors. Globally, 2.3 billion people consume alcohol *(1)*. In 2019, alcohol consumption caused 2.6 million deaths *(2)*. The harm caused by alcohol consumption imposes a substantial economic burden on societies. A 2021 review estimated societal costs at US$ 1872 per drinker annually, with 61% stemming from indirect costs such as lost productivity and premature mortality *(3)*.

The physical availability of alcohol is a determinant of alcohol consumption and related harm. Licensing is one way to manage the number, locations and operations of alcohol outlets *(4, 5)*. Licensing provides a platform to establish additional rules for alcohol outlet practices, such as limiting their hours and days of sale, setting minimum legal ages for customers and regulating home delivery *(4)*. More outlets means easier access and greater competition, which can drive lower prices and higher consumption *(6)*. Areas with more alcohol establishments experience higher rates of violence, suicide, child abuse, hospitalization and liver disease *(7–9)*. Alcohol outlet practices, such as their hours and days of sale, are also associated with rates of harm in the surrounding areas. In particular, restricting late-night alcohol sales may reduce alcohol-related violence, at least in part because longer hours of sale enable customers to reach higher levels of intoxication *(10)*. A 2010 systematic review found that reducing alcohol sales by two hours was effective in decreasing harm *(11)*. A 2002 policy measure reducing bar hours from 24 hours to 23:00 closing in Diadema, Brazil led to nine fewer homicides per month *(12)*. In Copenhagen, Denmark, coronavirus disease 2019 (COVID-19) policy limiting opening hours from 5:00 to 24:00 was linked to a 28% reduction in violent crime per square kilometre *(13)*. Violent crime fell by 23% after reducing bar and tavern hours of sale from 6:00 to 2:00 to 9:00 to 22:00 in Baltimore, Maryland, United States of America *(14)*.

The burden of alcohol-related harm is higher in historically deprived communities *(15)*. The overexposure to alcohol outlets in deprived neighbourhoods contributes to disparities in their associated harm such as noise, litter, public intoxication and violence *(16)*. The excessive concentration of alcohol outlets raises equity concerns, making their regulation an equity strategy. Regulating the number, location and practices of alcohol outlets can reduce alcohol-related harm and health inequalities, leading to safer, healthier communities.

Minimum legal purchase age laws are effective in reducing consumption and harm among young people *(17)*. Young people experience disproportionately higher harm from consuming alcohol. Early initiation into alcohol consumption increases the likelihood of negative consequences from that use later in life *(18, 19)*. However, the effectiveness of minimum legal purchase age laws depends on compliance monitoring as well as swift and certain penalties for infringement *(20)*.

The current expansion of alcohol home delivery has raised public health concerns that remain largely unexamined. Evidence suggests that increased availability through home delivery may elevate per capita alcohol consumption and alter drinking patterns, such as increasing solitary drinking – a risk factor for alcohol use disorders *(21)*. In addition, by reducing the full price of alcohol – accounting for both retail cost and convenience – home delivery may further drive consumption and heavy drinking *(6, 22–26)*. A key concern is the availability of alcohol to young people and those with alcohol use disorders, since home delivery may lack robust age verification at purchase and delivery points, especially when third-party drivers – often unlicensed and

untrained – handle orders *(26–30)*. Data from multiple countries indicate that underage buyers readily obtain alcohol via delivery, with third-party services having especially high failure rates in verifying age.

Alcohol licensing also enables compliance monitoring by documenting the locations and permitted activities of alcohol outlets, possibly also home delivery.

In 2019, 72% (92 of 128) of countries without a total ban on alcohol sales reported having a retail alcohol licensing system for beer sales, 72% (92 of 127) for wine and 73% (93 of 126) for spirits *(31)*; 67% (89 of 137) of countries restricted the locations of on-premise and 60% (79 of 131) off-premise beer sales *(31)*. Fewer countries restricted outlet density (23% [30 of 128] for on premise and 22% [27 of 125] for off premise), hours of sale (56% [75 of 133] for on premise and 53% [69 of 131] for off premise) and days of sale (29% [38 of 131] for on premise and 30% [39 of 131] for off premise) for beer *(31)*.

Similarly, 68% (90 of 132) of countries restricted the locations of on-premise and 61% (79 of 130) off-premise wine sales *(31)*. Fewer countries restricted alcohol outlet density (24% [31 of 128 for on premise and 22% [28 of 127] for off premise), hours of sale (56% [74 of 132] for on premise and 52% [67 of 130] for off premise) and days of sale (31% [40 of 130] for on premise and 31% [40 of 129] for off premise) for wine *(31)*.

For spirits sales, 68% (88 of 130) of countries restricted the locations on premise and 60% [77 of 128] off premise *(31)*. Fewer countries restricted alcohol outlet density (24% [30 of 128] for on premise and 20% [26 of 127] for off premise), hours of sale (58% [76 of 130] for on premise and 51% [66 of 130] for off premise) and days of sale (29% [38 of 129] for on premise and 29% [37 of 129] for off premise) for spirits *(31)*.

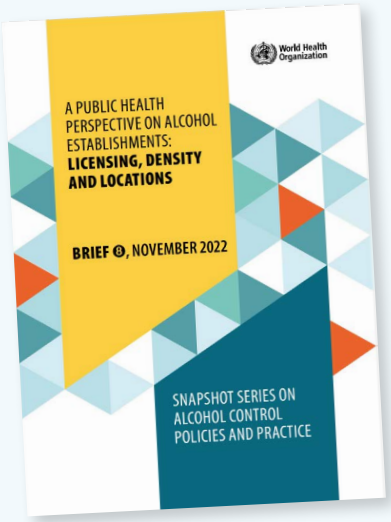
Also in 2019, 94% (125 of 133) of countries without a total ban on alcohol sales reported a minimum legal age for drinking. No differences were reported for on and off premises or type of alcoholic beverages; in one of these countries, the minimum age varies subnationally *(31)*.

These figures illustrate the potential for applying policy measures that restrict the availability of alcohol to reduce its consumption as countries pursue the Sustainable Development Goal targets in the framework of the global commitments of the WHO global strategy to reduce the harmful use of alcohol and its global action plan for 2022–2030 *(32, 33)*. However, knowledge is limited about how countries apply these policy measures, which context adaptations are needed and what challenges their implementation. This brief seeks to address this gap.

What this brief is about

A comprehensive review of policy measures to restrict the physical availability of alcoholic beverages is available in another brief of this series (Box 1). These policy measures are commonly applied through laws and regulations. An upcoming WHO publication provides a country-comparative legal analysis on how to address the availability, advertising, marketing and affordability of alcoholic beverages ■

Box 1. A public health perspective on alcohol establishments: licensing, density and locations



In off-premise establishments that sell other goods along with alcohol, customers are more likely to bundle the purchase of alcohol with other shopping. The consumption-related harm associated with off-premise establishments tends to cover a large area, whereas acute harm occurs close to places where people drink alcohol. People consume alcohol alongside others onsite at on-premise outlets. Bringing consumers together is one reason for a strong association between violence and the density of bars and nightclubs. Harm from alcohol tends to occur near the point of consumption, but alcohol delivery services shift the point of consumption from on-premise establishments to private settings. Policy options to govern alcohol establishments include addressing their practice, density and placement. In designing, implementing and enforcing policy options to restrict the physical availability of alcohol, policy-makers must balance the competing interests of diverse stakeholders. However, approaches that engage communities are more likely to be more equitable.

Source: *A public health perspective on alcohol establishments: licensing, density and locations (5)*.

The evidence: country policy measures to restrict alcohol availability

The WHO global strategy to reduce the harmful use of alcohol and its global action plan for 2022–2030 consistently call for restricting the physical availability of alcohol as one of the high-impact interventions to reduce alcohol consumption in pursuing the Sustainable Development Goal targets. The operational technical package, SAFER, gathering the most effective and cost-effective interventions, provides concrete guidance on the possible policy measures to adopt, how to adapt them to local contexts and the monitoring directions for countries to protect public health over vested interests *(34)*.

This brief adopts these policy frameworks to document and summarize alcohol availability policy measures in 30 countries representing 29% of the world's population (Fig. 1). The data were collected in 2022 and were analysed in 2023, using a legal epidemiology approach. Countries were selected from those that reported a national beer retail licensing and/or alcohol outlet density policy on the Global Survey on Alcohol and Health in 2012, 2016 and 2019 and did not have a total ban on alcohol in 2019. Low- and middle-income countries were given priority because of the larger knowledge gap and because they represent two thirds of the sample. Preference was also given to countries with larger populations to elicit the complexities and challenges related to implementing these measures in such settings.

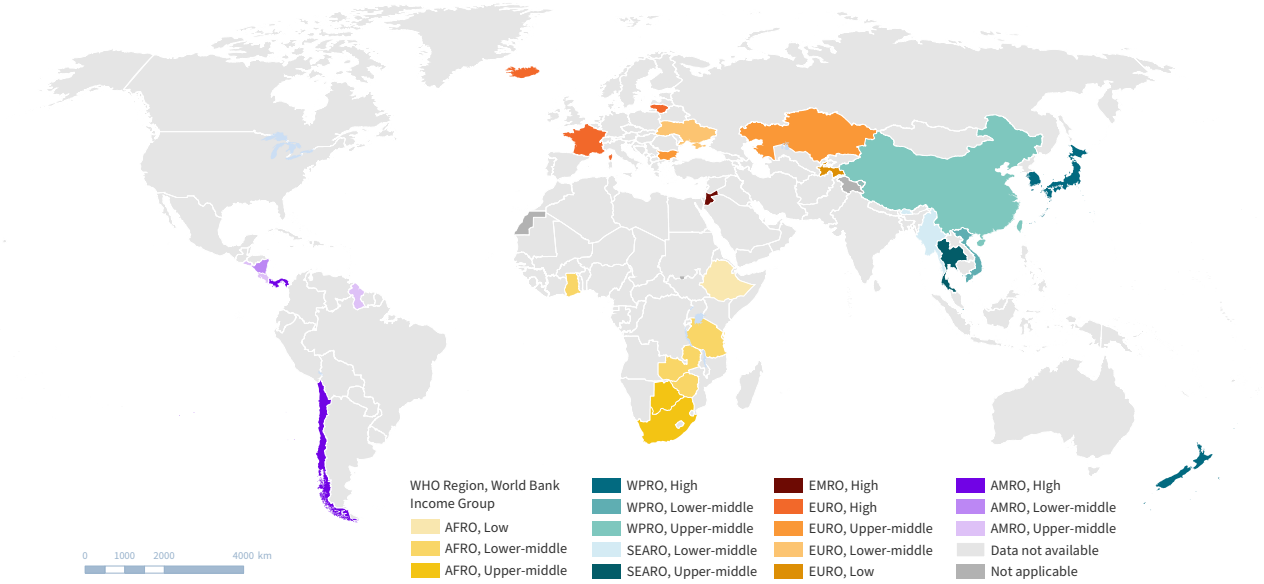
The data collected in 2022 and analysed in 2023, using a legal epidemiology approach, represents 29% of the world's population

A group of experts searched for countries' alcohol licensing policy measures using a standardized process. A snowball procedure identified additional applied measures. With this process, relevant documents referenced in the licensing system were obtained, read and coded. Some countries have complex policy systems to manage alcoholic beverage sales. This initiative did not identify all other policies that regulate any aspect of alcohol licensing, such as general business. Two trained coders extracted data from policies and accompanying regulatory frameworks by applying a standardized codebook; a third coder compared the two entries and resolved discrepancies.

All countries included in this study had national alcohol policies and regulatory frameworks. However, in a few cases, national laws explicitly delegated authority to subnational jurisdictions, such as for licence categories, hours or days of sale and penalties, and other aspects of the regulation were set at the national level.

This study focused on the formal market of alcoholic beverages. However, many countries in the sample have large informal alcohol sectors: part of an economy in which economic activities are not regulated or monitored by the government. The findings presented in this brief should be interpreted with this limitation in mind.

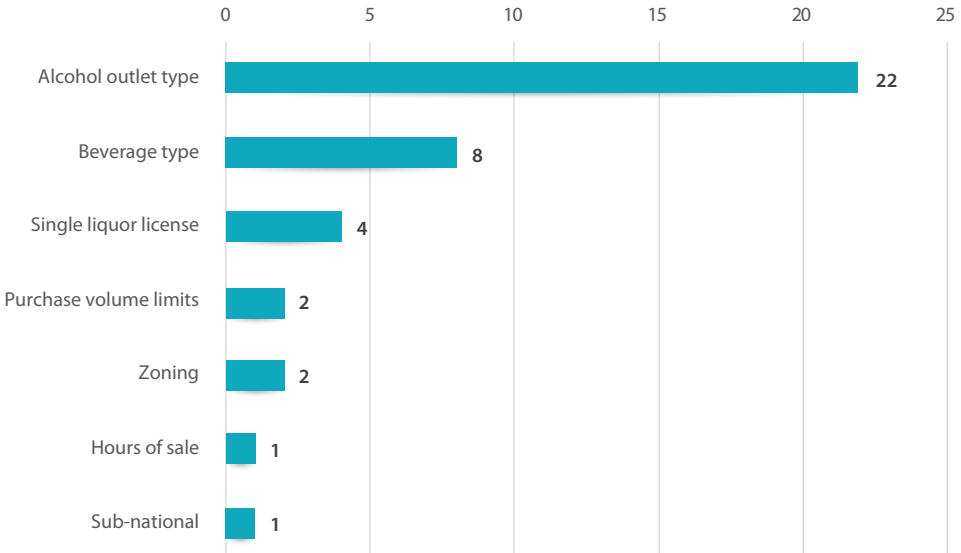
Fig 1. Selected countries included in this analysis



Alcohol licensing system

Countries focus on specific features of alcohol outlets to categorize alcohol licensing systems more stringently (Fig. 2). The most common one is outlet type (n = 22), although countries took different approaches to defining outlet types. Some countries specified whether outlets may sell for on- or off-premise consumption, and some used the nature of their business, such as bars, nightclubs and grocery stores. The second most common feature used to categorize alcohol licences was the types of alcohol outlets were permitted to sell. These distinctions facilitate regulators collecting beverage-specific taxes and limit sales of beverages with higher alcohol by volume *(35–40)*. Four countries had a single type of alcohol licence. Of these, one was a general business licence. Finally, one country delegated authority for defining the types of liquor licences to subnational jurisdictions, and these types of licences were not captured in the analysis.

Fig 2. Main alcohol outlet features used to categorize alcohol licenses, by number of countries

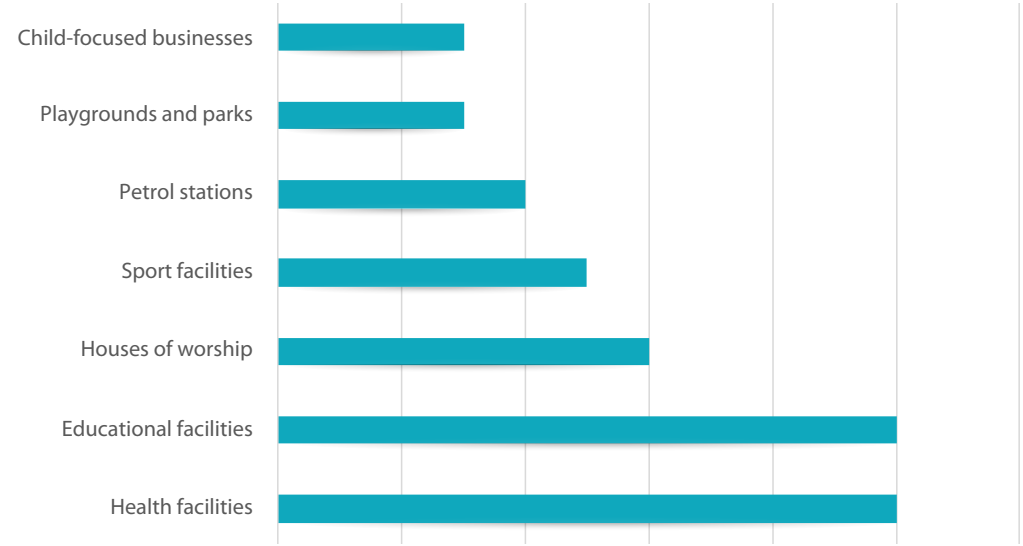


Note: n=29 countries that described alcohol licensing systems. Countries may categorize alcohol licenses using one or more of the above features
Source: own elaboration

Outlet location and density

Policy measures that limit the availability of alcohol aim to lower alcohol consumption and reduce related problems by making alcohol more difficult to obtain *(5)*. The review of the application for an initial alcohol licence establishes the types of businesses that may obtain an alcohol licence, where outlets may open and how many outlets may locate in a certain area. In this sample, 12 countries prohibited alcohol sales at some locations (Fig. 3). These bans were most common at educational and health facilities, houses of worship and sport facilities, including stadiums.

Fig 3. Most common locations where alcohol sales are banned, by number of countries

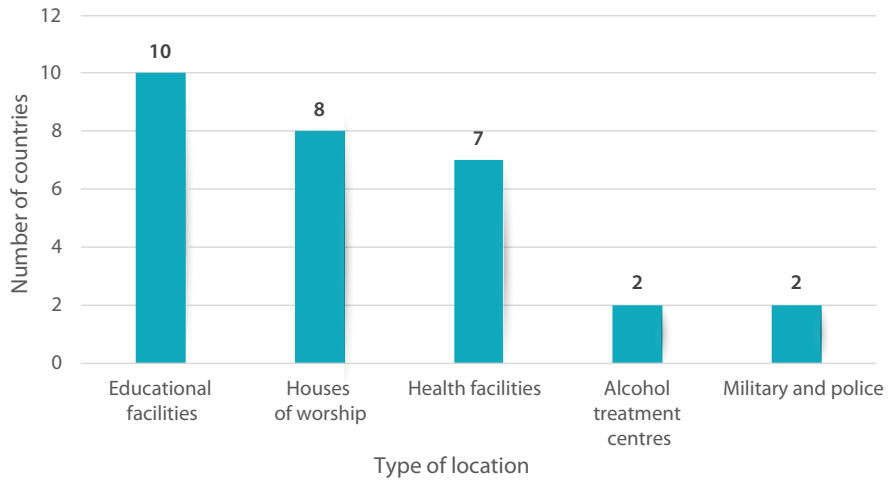


Note: *n* = 12 countries that ban alcohol sales in one or more location. Countries may ban alcohol sales in more than one location.

Source: author's own elaboration.

Ten countries had policies establishing a minimum required distance between alcohol outlets and sensitive locations (Fig. 4). Every country with a minimum distance requirement included limits on how closely an alcohol outlet could open near educational facilities. Similar to the bans on the types of businesses that could obtain alcohol licences, minimum distance restrictions for houses of worship and health facilities were also common. Required distances ranged between 100 and 500 metres. One country gave alcohol licensing authorities discretion to ban outlets in the immediate vicinity of the locations without defining this term.

Fig. 4. Most common locations for which minimum distance standards exist by number of countries distance standards exist, by number of countries



Note: *n* = 10 countries with a policy establishing a minimum distance between alcohol outlets and sensitive locations. Countries may require a minimum distance between alcohol establishments and more than one type of location.

Source: authors' elaboration.

Policy measures on alcohol outlet density aim to prevent neighbourhoods from becoming oversaturated with alcohol outlets (Box 2). These limits are important policy levers to prevent and reduce morbidity and mortality related to alcohol consumption since areas with higher alcohol outlet density have higher rates of hazardous drinking, violence and other types of related harm *(7–9)*. Five countries had a national policy on alcohol outlet density that established a population quota (data not shown). In these policy measures, thresholds were set at one establishment per every 300, 450, 600 or 1000 inhabitants. The fifth country set different thresholds for capitals (1:500) and municipalities (1:400). In addition, one country required a minimum distance (100 metres) between alcohol outlets to prevent clusters from forming.

Box 2. Alcohol outlet density restrictions in France

France's alcohol outlet density policy describes the types of outlets affected using licence categories, the outlet-to-population thresholds – quota – and how the number of outlets per population would be calculated *(41)*. This policy also articulates that the interpretation of calculated alcohol outlet densities per population should be interpreted conservatively as any ratio that exceeds one establishment for every 450 people. This level of detail facilitates government surveillance and compliance monitoring of alcohol outlet density.

"[Granting a new liquor licence is] impossible in the municipalities where the total of outlets of the third [restricted on premise] and fourth category [large on premise] reaches or exceeds the proportion of one per 450 inhabitants or a fraction of this number. By way of derogation, this provision does not apply to outlets whose opening occurs following a transfer carried out under the conditions set by article L3322-11. The population to be considered for this calculation is the total municipal population that results from the last census.

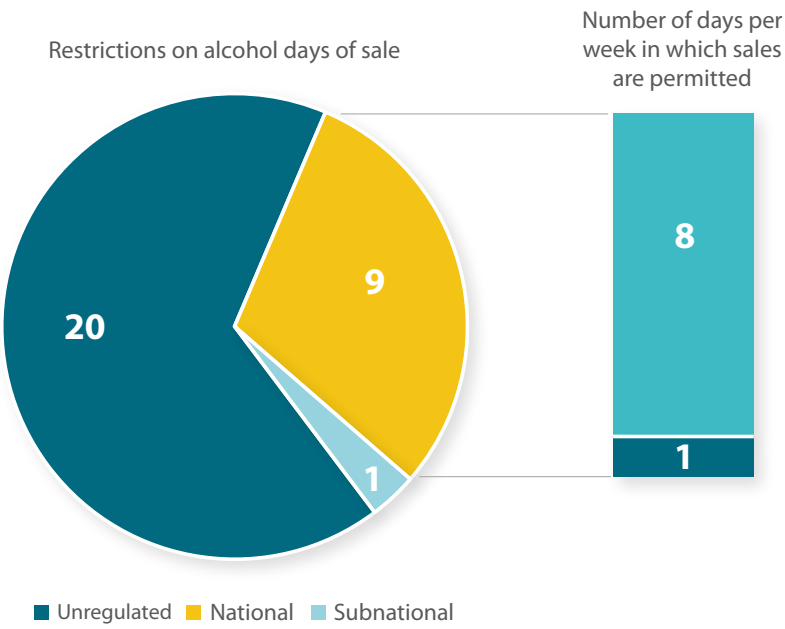
Calculation of the quota: Subject to the sovereign interpretation of the judge, the calculation of the quota mentioned in L3332-1 is of restrictive interpretation. It is therefore the crossing of each fraction of 450 inhabitants that enables the municipality to have a new operating outlet with a licence III."

Hours and days of sale

Another objective of policy measures that restrict temporal availability of alcohol by limiting the hours and days of sale is to reduce the convenience of obtaining alcohol, especially during high-risk hours and periods, such as late at night or during mass events. Limiting late-night alcohol sales may help reduce the harm caused by alcohol consumption because customers may reach higher blood alcohol concentrations when establishments are open longer *(10)*. Growing literature demonstrates that introducing new limits on alcohol hours of sale is associated with a decline in violence *(12–14)*.

Policy measures that limit alcohol days and hours of sale may focus on a conventional week or holidays and special events. This study collected data on limits during a conventional week because these measures will likely be more strongly associated with alcohol consumption and related harm at an aggregated population level. Policy measures on days of sale are often overlooked. Indeed, most alcohol licensing policy measures did not mention the days on which alcohol could be sold. Only nine of the 30 countries (30%) regulated days of sale at the national level (Fig. 5). Of these nine countries, just one limited alcohol outlet operations to six days per week. The other eight countries permitted alcohol sales every day of the week. One country delegated the authority for regulating the days of sale to subnational jurisdictions, and these subnational regulations are not captured in the analysis.

Fig. 5. Regulations on alcohol days of sale by number of countries

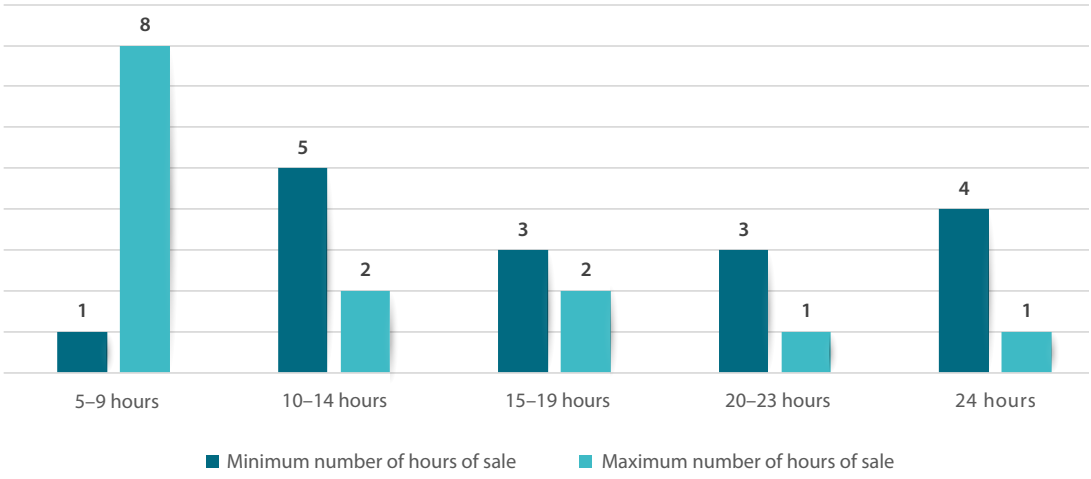


Note: *n* = 30 countries

Source: authors' elaboration.

More than half the countries (16 of 30, 53%) had a national policy restricting alcohol outlet hours of sale. Of these, half (8 of 16, 50%) limited alcohol sales to between 5 and 9 hours per day for the licence type and/or days with the most restrictive hours (Fig. 6). Seven countries (7 of 16, 44%) allowed at least one licence type to sell alcohol for more than 20 hours per day, including four countries that had at least one licence type that was permitted to remain open for 24 hours. Most countries' policy measures made explicit the hours of sale, such as "until 18:00" or "from sunrise to 21:00". Only a few low- and lower-middle-income countries have this kind of non-specific range or descriptors that rely on stages of the day rather than hours of sale, inserting unnecessary ambiguity into the laws and making them less easily enforceable.

Fig. 6. Maximum and minimum number of hours of sale per day, by number of countries



Note: *n* = 16 countries regulating hours of alcohol sale.

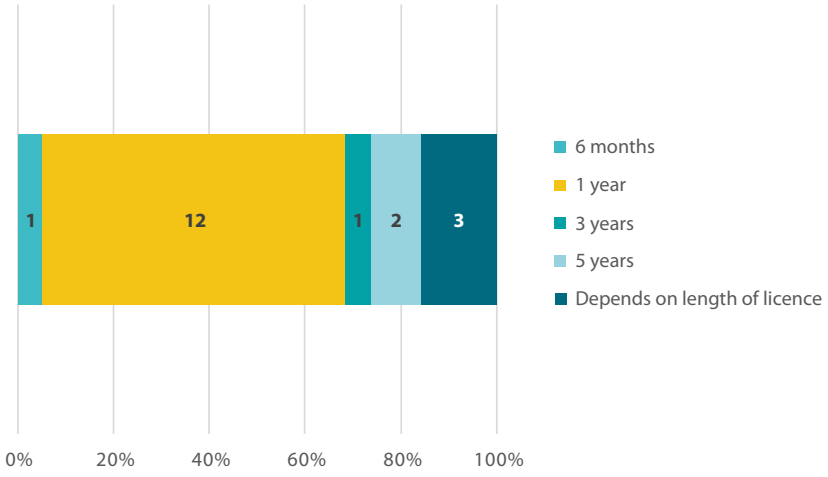
Source: authors' elaboration.

Licence renewals and community involvement

Requiring alcohol licence applications to be publicly announced is essential to community members determining whether to protest the alcohol outlets from entering their neighbourhood. Nine (9 of 30, 30%) countries required new alcohol licensing applications to be displayed publicly, such as in newspapers or online. Ideally, such public notifications should occur in a consistent location, so community members know where to look for news about alcohol establishments. Requiring alcohol licence renewal more frequently generates more licensing fee revenue and provides more opportunities for community members to protest alcohol establishments that are creating nuisances and harm.

In this sample, most countries (19 of 30, 63%) required licensing renewals on a set schedule, most commonly one year (Fig. 7). Twelve (12 of 30, 40%) countries included instructions for how communities can protest licences during the application and renewal phase (Fig. 8).

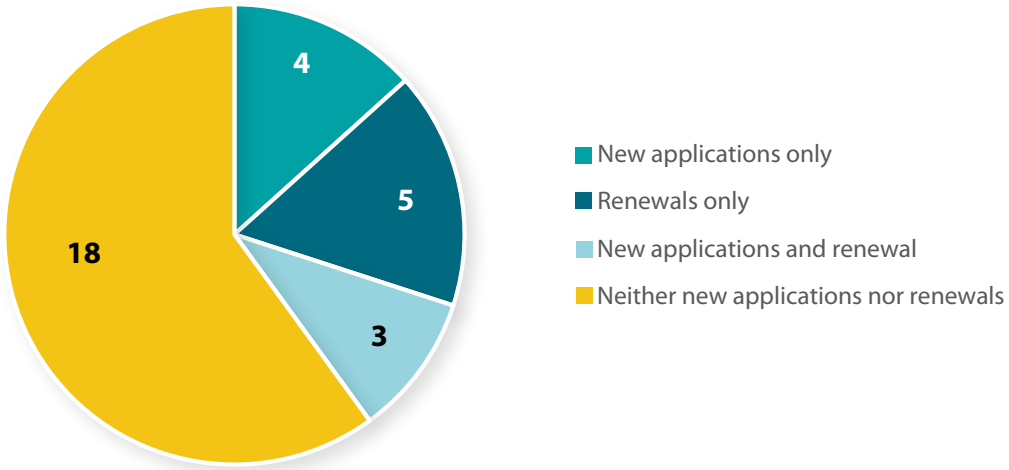
Fig. 7. Alcohol licence renewal periods by number of countries



Note: *n* = 19 countries that specify an alcohol licence renewal period.

Source: authors' elaboration.

Fig. 8. Community input during licensing applications and renewals by number of countries



Note: *n* = 30 countries.

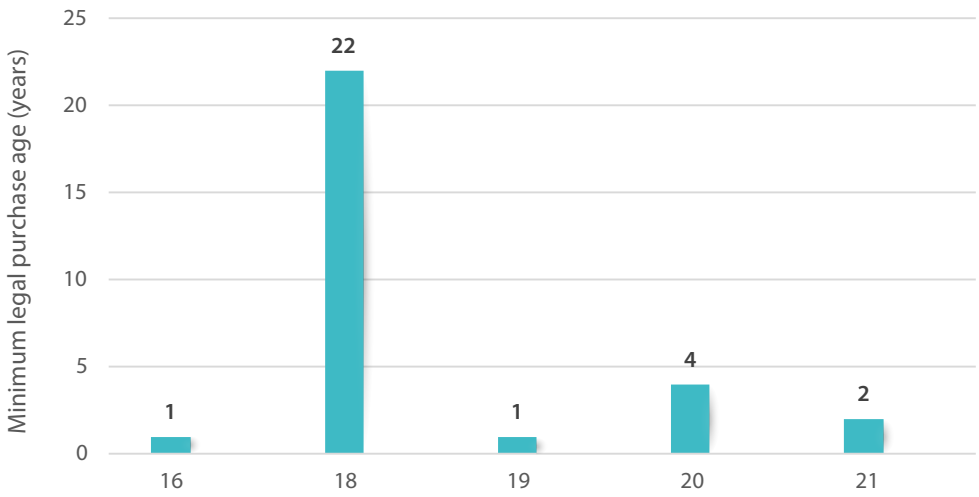
Source: authors' elaboration.

Minimum legal purchase age

Minimum legal purchase age policy measures are important determinants of how people access and consume alcohol across their life-course, since those who can legally begin using alcohol at earlier ages tend to engage more frequently in heavy episodic drinking as adults *(42)*. Evidence consistently shows that countries that raise the minimum legal purchase age subsequently experience lower rates of alcohol-related harm, especially road crashes. The minimum legal purchase age complements other age restriction policy measures such as minimum legal age for consuming alcohol, minimum legal age for consuming alcohol on-premises.

All 30 countries established a minimum legal purchase age (Fig. 9), and these ages did not differ for on- and off-premise alcohol sales. The most common minimum legal purchase age was 18 years (22 of 30, 73%). Of the remaining countries, seven established a minimum legal purchase age older than 18 years and one country younger.

Fig. 9. Minimum legal purchase age, number of countries



Note: *n* = 30 countries.

Source: authors' elaboration.

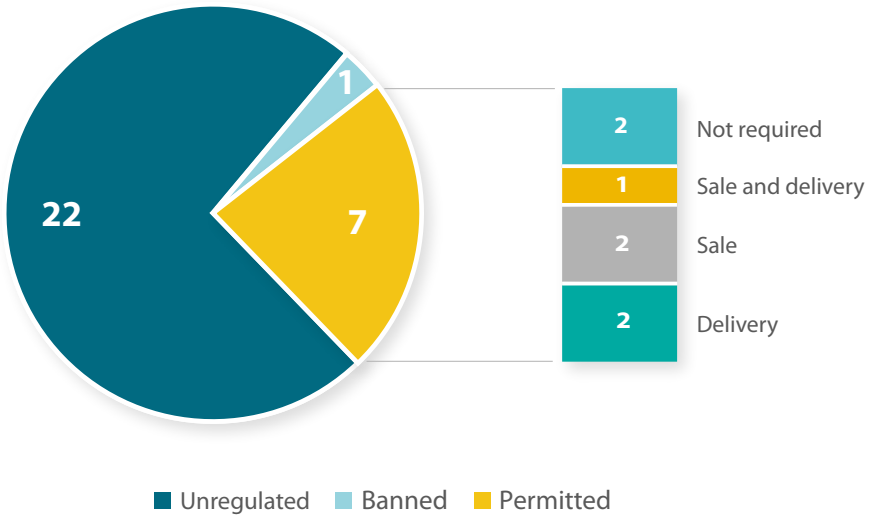
Alcohol remote sales and home delivery

Remote alcohol sales, alcohol delivery and direct shipping became increasingly common during the COVID-19 pandemic *(43)*. Preliminary data suggest that allowing alcohol delivery may exacerbate harm, since it may promote heavier alcohol use and/or drinking alone *(44)*.

Alcohol delivery was largely unregulated, with most countries (22 of 30, 73%) not mentioning remote alcohol sales or delivery explicitly in their policies (Fig. 10). Of the eight countries that regulated alcohol delivery, only one banned it. These policy measures were most common among high-income countries (5 of 8, 63%).

The rigorous verification of age during alcohol delivery ensures that this increasingly common alcohol sales practice does not provide a source of alcoholic beverages for underage young people. Among the seven countries with national policies allowing alcohol delivery, two required age verification at the point of sale, two required it at the point of delivery, one required it at both points, and two did not explicitly require age verification.

Fig. 10. Number of countries regulating alcohol delivery including age verification requirements



Note: *n* = 30 countries.
Source: authors' elaboration.

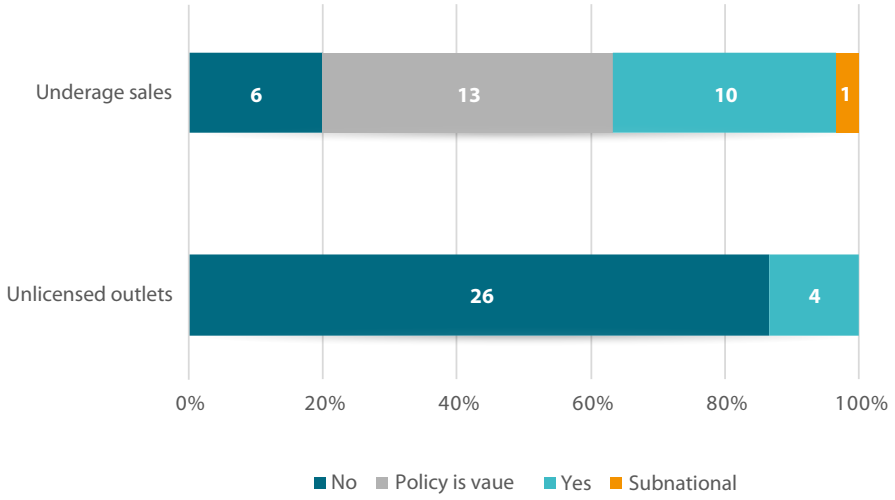
Compliance monitoring and penalties

Compliance checks are essential to obtain the full benefits of policies. Frequent compliance monitoring can reduce sales to minors, underage drinking and road crashes *(20, 45, 46)*. Studies have estimated that increasing compliance checks may reduce by 17–63% the likelihood that outlets sell alcohol to minors *(46, 47)*. However, the effects of compliance checks tend to diminish over time, and conducting them regularly is therefore essential to success. The most effective compliance checks are routinely conducted by trained law enforcement agents using standardized protocols, such as deploying underage decoys who attempt to purchase alcohol from retailers, placing undercover law enforcement officers in alcohol outlets to detect people under the minimum legal age attempting to purchase alcoholic beverages or targeting adults who provide alcohol to underage people *(48, 49)*. Effective compliance mechanisms should define the authorities responsible for enforcement, specifying their powers to implement, those liable for violations, the procedures for enforcement and the sanctions for violations *(50)*. Compliance checks lead to measurable results when applied with other initiatives, involve communities and combine media and awareness campaigns *(50)*.

Describing compliance monitoring procedures in policies can help ensure that such activities are effective and occur regularly. Less than half of countries (10 of 30, 33%) described enforcement activities for underage sales, and only four countries outlined compliance activities intended to bring unlicensed outlets into the formal alcohol market (Fig. 11). Most countries (6 of 10, 60%) with procedures

to verify age were high-income countries, suggesting potential for enhanced compliance monitoring to reduce underage drinking and associated harm in low- and middle-income countries. One country delegated the authority for enforcing activities for underage sales to subnational jurisdictions, and these subnational regulations are not captured in the analysis.

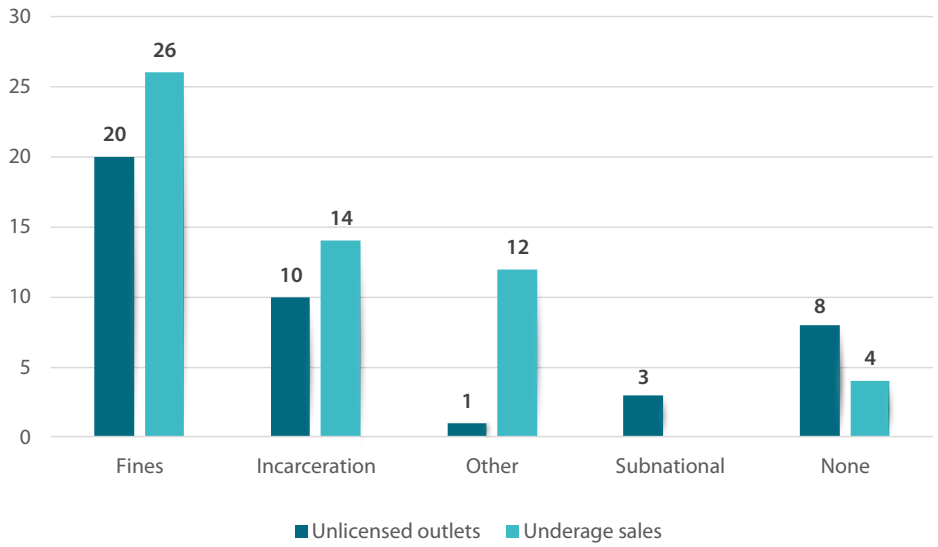
Fig. 11. Proportion of countries with measures to enforce underage sales and licensing provisions



Note: *n* = 30 countries. Countries may apply more than one type of penalty for each type of violation, so the numbers may not add up to 30.
Source: authors' elaboration.

Compliance monitoring is most effective when penalties are swift and certain. Describing the penalties for infractions detected via compliance monitoring was more common than detailing the compliance processes. Fines were the penalty implemented most often (Fig. 12). Several countries also included incarceration as a potential penalty, often for those who repeatedly violated alcohol sales regulations. Other penalties include deducting administrative points to a given licence, suspending or cancelling the licence and mandating reduced hours. At least three countries delegated the authority for establishing the types of penalty for unlicensed outlets to subnational jurisdictions, and these sub-national regulations are not captured in the analysis ■

Fig. 12. Types of penalties for underage sales and licensing infractions by number of countries



Note: *n* = 30 countries.
Source: authors' elaboration

The know-how: country case studies

This section describes how policy measures restricting the availability of alcohol are applied for addressing public health concerns in specific contexts, including how they are enacted and their potential benefits. Some of the policy measures showcased have not yet been evaluated but still usefully illustrate the types of changes that may help countries address problems associated with high alcohol availability.

Setting minimum distance standards for on-premise outlets in Botswana

In 2003, the Botswana National Strategic Framework for HIV/AIDS and the Substance Abuse and Drug Trafficking Strategic Plan recognized the use of alcohol as a major contributor to the HIV/AIDS epidemic, prompting the development of a national alcohol policy *(51)*. That same year, the Trade and Liquor Act of 1986 was divided into the Trade Act and the Liquor Act to enable tighter control over alcohol sales *(52)*. However, the Liquor Act was not implemented for another five years. The regulations that accompanied the Liquor Act of 2003 established minimum distance standards for both on- and off-premise retail alcohol outlets, requiring that they be located at least 500 metres away from schools, highways or major roads and churches and other controls *(53–55)*.

In 2007, about half of all adults (47%) consumed alcohol and more than half (54%) of consumers engaged in binge drinking in Botswana *(56, 57)*. Alcohol caused 56 deaths per 100 000 population, about half of which occurred among men 15–49 years old *(58)*. HIV was a leading cause of death, and 24% of those 15–49 years old were living with HIV in 2006 *(59)*. Alcohol consumption was a key risk factor for HIV transmission, disease progression and reduced medication adherence *(60)*. Studies have demonstrated links between alcohol consumption and unprotected sex, having multiple partners and worsening HIV treatment outcomes *(61–63)*. Alcohol was also a prominent risk factor for other leading causes of death and disability, including gender-based violence and noncommunicable diseases *(64, 65)*. Botswana has long recognized preventing alcohol use as a priority, and yet progress in developing and implementing evidence-informed alcohol policies was often sidelined because of the HIV epidemic or the interference of the alcohol industry *(53)*.

In 2008, the Liquor Regulations mandated that "the licensing authority shall not issue a licence under the Act where the proposed business premises are not at least 500 meters away from a school, highway, major road or church" *(54)*. At the time, this applied to both on- and off-premise outlets. However, in 2018, bottle stores, liquor wholesalers and liquor distributors were exempted from the 500-metre distance requirement, since they are for off-premises consumption.

The regulations granted alcohol control authorities the power of implementation and enforcement, and the Liquor Act established such authorities at the district, subdistrict, city and town levels *(54, 55)*. However, the regulations were subject to interpretation as to how the licensing control authorities were to treat existing liquor licences located less than 500 metres from schools, highways, major roads or churches. Specifically, the regulations stated that these bodies may negotiate with a licensee whose licence was issued before these regulations came into force *(54)*.

The effectiveness of minimum distance standards in Botswana has not been evaluated. However, evidence indicates that this regulation may be very important. First, the density of alcohol outlets around schools is associated with young people's alcohol consumption and binge drinking *(66, 67)*. Since young people are especially vulnerable to how alcohol affects sexual behaviour, limiting its availability would likely help reduce risky sex practices that lead to HIV transmission among young people *(68)*. Second, limiting locations for on-premise alcohol outlets may help to reduce gender-based violence, including sexual assault.

Banning alcohol sales at petrol stations in Lithuania

Alcohol consumption rose steeply after Lithuania regained its independence in 1990 and alcoholic beverages were widely marketed, more readily available and cheaper *(69)*. In 2010, Lithuania had the highest rate of alcohol-attributable years of life lost among 30 European countries *(70)*. In 1995, Lithuania adopted the Law on Alcohol Control to reduce alcohol consumption, availability and related harm *(71)*. The Law established a national retail alcohol licensing system *(71, 72)*.

In 2010, Lithuania had the ninth highest alcohol-related road crash rate among countries in the European Union, with 12.8 alcohol-related road crashes per 100 000 population *(73)*. Consequently, a ban on alcohol sales at petrol stations to reduce drink-driving and disconnect alcohol from driving behaviour was pursued *(74)*. Notably, this ban was part of a coordinated effort to strengthen alcohol control policies across the WHO "best buys", including new restrictions on alcohol availability, pricing and marketing *(75)*.

In 2011, an amendment to the Law on Alcohol Control removed the text granting petrol stations permission to sell alcohol, effectively banning alcohol sales in petrol stations since 2016 *(76)*. Petrol stations engaging in retail alcohol sales were then subject to a fine for unlicensed alcohol sales *(77)*. The petrol stations and alcohol industries opposed the proposed ban, arguing that it would cause widespread job and revenue losses, violate equal competition conditions, discriminate against petrol stations and encourage illicit alcohol consumption *(78)*. Consequently, amendments to the Law on Alcohol Control were proposed to delay the ban on alcohol sales in petrol stations until 2019 (proposed amendment XIIP-2825) and to limit the ban to alcoholic beverages that contain >15% alcohol by volume starting in 2018 (proposed amendment XIIP-2837). Several alcohol prevention organizations and coalitions argued that such provisions would not serve the welfare of the people and would contradict the essence of the Law on Alcohol Control: to make alcohol less available, especially to young people *(78)*. In addition, a mystery shopper exercise found that 14 of 17 (82%) of the petrol stations surveyed sold alcohol to underage people *(79)*. Ultimately, the proposed amendments were not approved and the ban went into effect and applied to the sale of all alcoholic beverages in 2016. The ban on alcohol sales at petrol stations specifically has not been evaluated. However, an interrupted time-series analysis found that all-cause mortality fell during the larger period of policy change from 2001 to 2018 *(80)*.

Banning alcohol sachets in Malawi and Uganda

The high burden of disease and harm from alcohol consumption, especially how it affects the rise of noncommunicable diseases, HIV transmission, potential harm to young people and gender-based violence, led to a complete ban of alcohol sachets in Malawi (2017) and Uganda (2019). The public and government actors in Malawi and Uganda also perceived the widespread availability and consumption of alcohol sachets as leading to increased exposure for children, young people and other vulnerable populations and therefore leading to several social disorders, such as truancy, delinquency, road accidents, gender-based violence and littering. In both countries, concerns were raised also after the media reported some deaths linked to road crashes, such as among boda-boda motorcycle taxis. Worries were also expressed about the alcohol contained in the adulterated content of some sachets.

Box 2. Availability of alcohol sachets in Malawi and Uganda

©The Nation, Malawi

©UBL website, Uganda

Alcohol sachets are small plastic bags of about 30 to 250 ml, which makes them affordable, around US$ 0.10–0.50. They contain single-use quantities of high-strength spirits such as gin, whisky and other types of liquor. In Africa, alcohol sachets have been associated with heavier and more harmful consumption *(81, 82)*, especially among young people and more vulnerable populations *(83, 84)*.

The sachet bans in both Malawi and Uganda resulted from protracted policy and regulatory processes and systematic opposition. In Malawi, plastics manufacturers and alcohol producers mounted several legal challenges against the ban. In 2011, alcohol distillers brought a court injunction against the sachets ban and the Malawi Bureau of Standards. In 2015, plastics packaging manufacturers sought an injunction in the High Court. However, in 2017, a High Court ruling squashed the legal challenges, reaffirming a complete ban on alcoholic beverages sold in plastic sachets. In 2017, based on this ruling, the Ministry of Trade, Industry and Tourism closed 13 manufacturers that packaged alcohol in plastic bottles and sachets. In Uganda, the ban of sachets was issued first as an ordinance by the local Gulu District in 2016, with some resistance from the local alcohol industry. A Ministry of Trade directive followed later but with poor compliance by manufacturers. In 2019, the Ministry of Trade and the Uganda National Bureau of Standards reaffirmed the ban. In 2019, the National Alcohol Control Policy banned the sale of alcohol in sachets and other small packages of less than 250 ml for spirits, 750 ml for wines and 330 ml for beers. In 2023 and 2024, an alcoholic drinks control bill proposed a comprehensive regulatory framework for alcohol production, sale and consumption. The bill reiterated the ban on packaging, selling and importing alcohol in sachets and proposed a new ban on plastic bottles. Although the bill did not pass the scrutiny of the Parliament, it signalled continued legislative interest in addressing harmful alcohol use and regulating industry practices and sparked renewed national debate on alcohol-related harm.

Although the bans were mostly effective in removing alcohol sachets from sale, other products have emerged instead. In Malawi, small glass bottles of 200 ml or less containing high-strength alcohol are emerging. In addition, local market sellers purchase larger five-litre bottles and sell to consumers in small glasses, tots or nips at low prices. Similarly in Uganda, new smaller local factories are sprouting up to manufacture these small plastic bottles of 200 ml or less containing high-strength alcohol.

Both countries used strong enforcement mechanisms for the bans, including closing manufacturing outlets, seizing and destroying sachets and applying fines to some non-compliant sellers of sachets. As a result, in Malawi and Uganda, the bans were mostly effective in withdrawing alcohol sachets from sale *(85)*. However, other replacement products have emerged, increasing availability anew, in the form of small glass bottles in Malawi and small plastic bottles in Uganda *(86)*. The small bottles range from 100 to 300 ml and contain high-strength spirits, sometimes mixed with energy drinks or other flavours. These small bottles are widely available and can be purchased for US$ 0.30 to US$ 0.50. Moreover, some manufacturers in both countries are now selling alcohol in bulk (large containers or jerrycans), which is then repackaged and sold to demand at local level (using tots or nips). Therefore, policy measures focused on singular products or packaging may be inadequate to address alcoholic beverage availability without a more comprehensive approach *(86)*.

Emerged new products include small plastic or glass bottles with high-strength spirits, sometimes mixed with energy drinks or other flavours

Banning alcohol delivery in Thailand

To curb the harm stemmed by rising alcohol consumption, Thailand adopted evidence-informed policies and practices to address the marketing, price and availability of alcoholic beverages. In 2008, the Alcohol Beverage Control Act placed comprehensive restrictions on alcohol, including day and places of sales, certain selling methods, drinking venues and advertising in Thailand. In 2015, alcohol regulations limiting hours of sale and zoning areas around education institutes were consolidated and subordinated under the Alcohol Beverage Control Act *(87)*. Nevertheless, in 2018, Thailand reported one of the highest rates of alcohol consumption per capita in South-East Asia *(1)*.

In response to the first wave of the COVID-19 pandemic between March and May 2020, Thailand implemented social measures that restricted alcohol sales and services, including curfews, lockdowns on bars and pubs, restaurant closures and complete bans on alcohol sales either nationwide and in some provinces *(88)*. In response, bars innovated, launching delivery services for cocktails, bottled alcohol and drinking-mixing kits *(89)*. Studies revealed the proliferation in social media posts with content about alcohol sale promotion and delivery *(90)*. These concerns about easy and uncontrolled access to alcohol via electronic channels, especially among minors, together with the demands for a stronger enforcement of the Alcohol Beverage Control Act as part of COVID-19 outbreak preventions, were brought to the attention of the National Alcohol Control Committee.

In December 2020, a ban on electronic sales of alcoholic beverages entered into force under the Alcohol Beverage Control Act. In addition, any actions inducing the consumer to purchase alcoholic beverages, or related services, through marketing activities conducted via electronic platforms, wherein such information is communicated electronically and the consumer and the seller do not meet in person, was also prohibited. These measures did not bar payment by electronic means at stores, restaurants and other venues that serve alcoholic beverages *(91)*. Violations carry a fine and up to six months in prison.

However, the Royal Thai Police and Public Health Ministry strive to enforce the law, but alcohol sellers have appealed to the Administrative Court of Thailand.

The impact of these policy measures has not been assessed, likely because of the challenge of isolating the effects of one policy. However, an interrupted time-series analysis that used monthly data from 2004 to 2019 concluded that alcohol-related road crashes, injuries and deaths decreased after the policy measures, including a ban on alcohol sales at petrol stations, went into effect *(92)*. Although the effect of the online sales ban cannot be separated from other effects of the pandemic on nightlife and alcohol sales, good compliance has been observed on official e-commerce platforms, social media accounts of alcohol companies and chain stores after the enactment of the law.

Box 3. Policy and regulatory measures to restrict alcohol availability in Burundi

In 2016, Burundi had a prevalence of alcohol use disorders of 6.8% versus 3.7% in the WHO African Region as a whole, and the rate of heavy episodic drinking for the general population was 18.8% compared versus 17.4% in the WHO African Region *(1)*. Although men's alcohol consumption drives these figures, the prevalence of alcohol consumption among pregnant women is estimated to be between 16% and 32%, among the highest in the WHO African Region *(93, 94)*. In Burundi, alcohol consumption also strongly affects the burden of disease and road crashes *(1)*.

In 2014, a first set of policy measures aimed at regulating alcohol availability, including alcohol outlets, bars, restaurants and other establishments open to the public and manufacturing, marketing and consuming certain beverages and liquors *(95, 96)*. In 2016, Burundi's National Alcohol Policy stated an ambitious framework to reduce alcohol harm *(97)*. The restrictions on alcohol availability included setting the legal drinking age for on-premises alcohol service and off-premises alcohol sales at 18 years old, including the need for minors to be accompanied by parents or tutors to access nightclubs or bars *(98)*. The policy also prohibited the sale of alcoholic beverages to intoxicated individuals, along public highways and in outside terraces not authorized for this purpose. However, policy measures to restrict retail alcohol sales, including hours and location and alcohol-free public spaces and restrictions at specific events, have not articulated into a clear regulatory framework *(99)*. Other alcohol policy measures related to pricing and marketing also remain unclear or not legislated *(99)*.

Policies not backed up by a legislative and regulatory framework may lead to weaker implementation and enforcement. Other barriers to effective policies include engrained cultural and social practices that normalize alcohol consumption, industry interference in policy development, lack of policy tracking and monitoring systems and insufficient allocation of funds. These findings apply to many other countries in the WHO African Region *(100, 101)*. Alcohol policies require further integration and decisive multisectoral action across international, regional, national and subnational jurisdictions.

Banning consumption in public locations in Viet Nam

From 2004 to 2016, annual per capita alcohol consumption rose dramatically from 3.8 to 8.3 litres in Viet Nam *(102)*. As of 2015, alcohol consumption among young people was high: 80% of men and 36% of women 14–25 years old consumed alcohol, including 47% of people 14–17 years old of both sexes *(102)*. Among men, the prevalence of heavy episodic drinking rose from 25% in 2010 to 44% in 2016 *(102)*. From 2019, alcohol caused 8% of deaths and 7% of years of life lost, and its share of the total disease burden rose by 50% from 2010 to 2019 *(103)*. Nearly one third (29%) of women reported living with a heavy drinker, and an estimated 7% of children experienced alcohol-related physical harm or witnessed serious alcohol-related violence at home.

In 2017, the Ministry of Health was assigned to draft a new alcohol control law. The National Assembly Committee for Social Affairs, provincial authorities, civil society organizations and others played a role in supporting the policy change. The bill had its first reading in the National Assembly in 2018. In 2019, two drink-driving crashes spawned a march organized by the National Traffic Safety Commission and the Hanoi People's Committee *(102)*. This precipitated action on the proposed law and likely influenced its content.

In 2020, the Law for the Prevention and Control of Alcohol-Related Harm entered into force *(104)*. The Law laid out an extensive array of measures, encompassing cost-effective and high-impact interventions to address alcohol advertising and availability, screening and brief intervention, drink-driving and awareness. For restricting alcohol availability, the Law banned the consumption or sale of alcoholic beverages in health facilities, educational institutions, nursing care centres, recreational centres for minors, rehabilitation centres, compulsory educational institutions, reform schools, prisons and other retention facilities, social protection centres and workplaces of regulatory authorities, political organizations, sociopolitical organizations and public service providers, except where trade in alcoholic beverages was explicitly permitted. The Law expanded licensing to address home-brew and unregulated production of spirits with at least 5.5% alcohol by volume. It prohibited new alcohol outlets opening within 100 metres of health facilities, nurseries, infant schools, kindergartens and general education schools.

From 2004 to 2016, annual per capita alcohol consumption rose dramatically from 3.8 to 8.3 litres in Viet Nam

The Law allocated funding for collaborative efforts to prevent alcohol-related harm and targeted specific agencies and organizations to play roles in implementation. The same year, a subsequent decree banned alcohol consumption in bus stations, cinemas, theatres, cultural establishments, sports facilities and parks, except for licensed outlets located inside parks.

The immediate impact of the Law came by adopting zero tolerance for drink-driving for all drivers. Within a week of its entering into force, one hospital in Hanoi City reported that the number of people admitted with injuries from road crashes had fallen by half ■

The way forward

In accordance with the WHO global strategy to reduce the harmful use of alcohol, its global action plan for 2022–2030 and the operational technical package, SAFER, countries can adopt and enforce policy measures that limit alcohol outlet density, restrict trading hours, set minimum purchase ages and address unregulated markets for addressing the challenges of alcohol availability.

This requires collective intersectoral efforts across government actors but also building partnerships, especially with civil society, to mobilize public support and ensure effective implementation, and with academia to fill knowledge gaps. Aligning these efforts, stakeholders can create robust policy measures that reduce alcohol-related harm and protect public health.

Policy- and decision-makers

Policy- and decision-makers could:

- recognize that evidence-informed policies that restrict alcohol availability can promote health and safety, reducing downstream expenses associated with illness, injury and other harm;
- identify opportunities to advance regulations and standards on alcohol availability, such as hours of sale, days of sale and minimum distances between establishments and sensitive locations;
- invest in enforcement mechanisms by empowering regulatory oversight, conducting regular compliance checks, ensuring adequate funding, equipment and regular training for law enforcement officials, promoting intersectoral cooperation and information sharing among agencies and applying penalties for violations, including fines, revoking licences and instituting legal action;
- partner with civil society and community-based organizations to identify alcohol availability policy measures with public support;
- partner with and fund researchers to evaluate alcohol availability policy changes to communicate successes and identify opportunities for further refinement;
- consider inclusivity and equity when designing alcohol availability policy measures, including how they may affect diverse subpopulations and ways to involve communities in the alcohol licensing processes; and
- consider ways to prevent vested interests in developing and implementing policy, such as by developing a conflict-of-interest policy that prevents those with financial ties to the alcohol industry from serving on alcohol licensing boards.

Civil society and community-based organizations

Civil society and community-based organizations could:

- advocate for evidence-informed alcohol availability policy measures that would address problems in their communities;
- conduct public opinion polling to identify alcohol availability policy measures with broad public support; and
- document and share the experiences of countries and localities that implement evidence-informed alcohol availability policy measures to facilitate their adoption in other locations.

Researchers and research institutions

Researchers and research institutions could:

- identify the most pressing public health problems related to alcohol availability to support evidence-based setting of priorities among policy measures;
- assess changes in alcohol availability policy measures overall and in relation to alcohol-related disparities; and
- evaluate the effects of different approaches, providing actionable insights to guide policy adaptation.

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Annex 1. Selected Policy measures and interventions for restricting alcohol availability

This annex provides an overview of possible policy measures and areas of interventions for restricting the availability of alcoholic beverages. It is a selective list of the most common features to guide policy development. The list supports the establishment, operation and enforcement of an appropriate public health–oriented system to regulate production, wholesaling, selling, serving and consumption of alcoholic beverages.

Measures and interventions can be applied to systems for alcohol retail sale, alcohol outlets, modalities of retail sales, characteristics of products, people's rights and responsibilities and the environment: public settings where people live and work.

These policy measures and areas of intervention could be applied differently depending on the beverage type, such as for beer, wine, spirits and other types of alcoholic beverages. They apply to national or subnational jurisdictions. Measures and interventions could also account for on-site and off-site consumption.

This annex also provides pointers for considering aspects related to monitoring and enforcement and a glossary of main terms used.

Alcohol availability selected policy measures and interventions

Systems
Managing to preserve government monopolies
Establishing standards for government monopolies on retail sales
Licensing alcohol establishments
Frequency for renewal
Types of licences
Community involvement for new application and renewal
Penalties for noncompliance
Public advertising of the licence application
Penalties for noncompliance
Permitting or prohibiting the sale of alcoholic beverages for off-site consumption by specific businesses
Petrol stations
Corner or convenience stores
Drug stores
Grocery stores

Unrecorded alcohol

- Address illicit production, distribution and sale
- Address homebrew production and consumption of alcoholic beverages, including the availability of methanol
- Combat the smuggling of alcoholic beverages across neighbouring countries
- Regulate informal markets
- Introduce tax stamps and labelling requirements for imported alcoholic products

Outlets

Establishing standards for location

- Minimum distance from specific areas or buildings, such as educational facilities, health facilities and addiction treatment facilities
- Minimum distance among alcohol outlets

Establishing standards for density

- Criteria for establishing a maximum of outlets per population or land area
- Differentiate maximum number among urban, peri-urban and rural area settings

Setting hours and days of retail sale

- Maximum hours of sale
- Maximum or specific days of sale
- Specific ranges or descriptors for hours of sale, such as until 18:00 or from sunrise to 21:00

Modalities

Defining modes of retail sales of alcoholic beverages

- Regulating alcohol remote and digital order and sales
- Vending machines

Regulating home delivery of remotely ordered alcoholic beverages

- Allowed or not for on-premise sellers and off-premise sellers
- Licensing third-party delivery services, such as ride-sharing services or taxicabs versus postal or mail delivery company

Product

Establishing standards for alcoholic beverage characteristics

- Composition of alcoholic beverages, including minimum and maximum alcohol content limits
- Size and types of containers for alcoholic beverages, such as banning sachets and small containers (200 ml or less)
- Packaging of alcoholic beverages
- Food safety standards for alcoholic beverages, including ingredients, health and nutrition claims and labels

People

Setting minimum legal age for consumption, purchasing and serving

- Minimum legal age for consuming alcoholic beverages in on-premise outlets
- Minimum legal age for purchasing alcohol
- Minimum legal age for serving alcoholic beverages in on-premise

Regulating commercial host and secondary liability
Safeguard and liability on outlet owners and attendants to prevent sales to intoxicated people and those younger than the minimum age
Safeguard and liability for secondary supply of alcohol to minors by parents, friends and community members
Mandatory training for service attendants and delivery drivers
Minimum age for purchasing alcohol remotely or online
Delivery person required to confirm the purchaser's age
Safeguards in remote selling of alcohol to intoxicated people
Environments
Regulating sales at specific events
Sporting events
Concerts
National, local and popular celebrations
Regulating sales in certain places
Educational facilities, health facilities and addiction treatment facilities
Houses of worship, workplaces, government premises and public transport
Movie theatres, beauty salons, recreation centres, playgrounds, public parks, public beaches and streets
Regulating consumption in public environments
Educational facilities, health facilities and addiction treatment facilities
Houses of worship, workplaces, government premises and public transport

Monitoring and enforcement

For each measure and intervention, assign responsibility for monitoring and providing enforcing means to restrict alcohol sales to government agencies or other stakeholders. For some measures and interventions, more than one agency and stakeholder may apply.

Potential government agencies involved

- ☐ Police or road safety
- ☐ Liquor law enforcement agency
- ☐ Trade, industry or commerce ministry
- ☐ Public health agency or related commission
- ☐ Tax revenue
- ☐ Customs office
- ☐ Civil society organizations or independent body, such as observatories or academia

Potential mechanisms for detecting violations of alcohol sales restrictions

- ☐ Active surveillance by mandated agency, such as tracking and tracing systems
- ☐ Government complaint system
- ☐ Case-by-case reporting

Potential penalties for infringements on alcohol sales restrictions

- ☐ Suspension or removal of licence to operate
- ☐ Fines
- ☐ Incarceration for a specified period of time
- ☐ Requiring employees to take training
- ☐ Warning
- ☐ Confiscation of goods

Glossary

On-premise sales means serving alcohol for customers to consume while they are in the establishment. On-premise outlets include cafés, pubs, bars, restaurants and hotels.

Off-premise sales means selling alcohol for the consumer to take away and drink somewhere else. Off-premise outlets include retailers such as stores, shops, supermarkets and petrol stations, depending on national legislation.

Locations of sales means places where alcohol may be sold by outlets or retailers. It does not include restrictions on sales during holidays.

Density of outlets means the number or concentration of on-premise outlets in a given geographical area, such as one establishment per 1000 population.

Restrictions on hours of sales refers to any limits based on the times that alcohol may be sold within a 24-hour period.

Restrictions on days of sales means any limits on the days on which outlets may sell alcohol during a regular seven-day week. Please do not include sales on holidays.

Total ban means that no alcoholic beverages can be consumed in these locations; they are always alcohol-free by law.

Partial ban means that certain alcoholic beverages are forbidden, drinking alcoholic beverages is forbidden during some times or some but not all offices, buildings or places in the category of places are alcohol-free. For example, alcohol consumption is forbidden at secondary schools but not on university campuses. It does not include single-day bans: for example, during a holiday.

Legal age limit means that alcoholic beverages cannot be purchased by a person younger than this age.

Remote ordering of alcohol includes the purchase of alcohol through a virtual outlet for delivery.

Unrecorded alcohol means alcohol that is not taxed and is outside the usual system of government control, such as home or informally produced alcohol, legal or illegal, smuggled alcohol, surrogate alcohol (alcohol not intended for human consumption) or alcohol obtained through cross-border shopping that is recorded in a different jurisdiction.

Alcoholic beverages contain ethanol, an established psychoactive and toxic substance that can cause dependence. They are associated with public health challenges. Policy measures that restrict alcohol availability have proven effective to reduce alcohol consumption, shaping consumption patterns and mitigating harm. This brief zooms into the policy measures applied in 30 countries. Results show that categorization of alcohol licensing is based on the types of outlets and alcohol sold. Countries commonly prohibit alcohol sales at some locations, such as educational premises, health facilities, houses of worship and sports sites. Fewer countries establish a minimum required distance between alcohol outlets and sensitive locations. Required distances ranged between 100 and 500 metres. Only one third of countries regulate the days of sale, but more than 50% restrict the hours of sale. Licensing renewals were commonly set at one year intervals. The most common minimum legal purchase age was 18 years. Alcohol remote sale and delivery were largely unregulated, with only a few countries requiring age verification at the point of sale or delivery. Fines were the penalty implemented most often. The brief shows how policy measures that restrict the availability of alcohol were applied for addressing public health concerns in specific contexts such as Botswana, Burundi, Malawi, Lithuania, Thailand, Uganda and Viet Nam. In all cases, coordinated, multisectoral approaches are needed to address the challenges of restricting alcohol availability.

Less Alcohol Unit
Department of Health Promotion

Website: https://www.who.int/teams/health-promotion/reduce-the-harmful-use-of-alcohol

E-mail: lessalcohol@who.int

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