WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU RÉGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL COMMITTEE

Seventy-sixth session
Nadi, Fiji
20–24 October 2025

WPR/RC76/7

29 August 2025

ORIGINAL: ENGLISH

Provisional agenda item 13

ALCOHOL CONTROL

Alcohol use remains a critical public health and development challenge for the Western Pacific Region. Alcohol contributed to more than 485 000 deaths in the Region in 2019, disproportionately affecting youth, women and marginalized populations. Despite growing evidence of harm − including links to more than 200 diseases and conditions − alcohol continues to be widely available, relatively affordable and aggressively marketed in the Region. As a result, the Western Pacific is currently not on track to achieve global targets and commitments to prevent and control noncommunicable diseases (NCDs), including the target set in the WHO *Global alcohol action plan 2022–2030* of a 20% reduction in per capita alcohol consumption by 2030, compared to 2010 levels.

The draft *Accelerating Implementation of the WHO Global Alcohol Action Plan 2022−2030 in the Western Pacific Region* builds on the *Regional Action Framework for Noncommunicable Disease Prevention and Control in the Western Pacific* and aligns with the Region's vision of *Weaving Health for Families, Communities and Societies in the Western Pacific Region (2025–2029)*. Developed through extensive Member State consultation, the regional implementation plan highlights alcohol consumption trends and related harms, and calls for accelerated action to address them, with flexibility to accommodate countries at all stages of policy development and implementation. The plan also suggests ways to integrate alcohol control into broader health and development agendas, including universal health coverage and NCD prevention and control efforts.

The Regional Committee for the Western Pacific is requested to consider for endorsement the draft *Accelerating Implementation of the WHO Global Alcohol Action Plan 2022−2030 in the Western Pacific Region.*

DRAFT
ACCELERATING IMPLEMENTATION OF THE WHO GLOBAL ALCOHOL ACTION PLAN 2022–2030 IN THE WESTERN PACIFIC REGION

1. BACKGROUND

According to WHO's *Global status report on alcohol and health and treatment of substance use disorders* published in 2024, alcohol was the cause of one death every minute in the Western Pacific Region in 2019. Alarmingly, nearly one in five deaths among men aged 20–29 in the Region is attributable to alcohol.

Alcohol is a psychoactive substance that exerts a significant impact on population health. All consumption involves some risk to health *(1, 2)*. Alcohol use can cause premature death and is linked to more than 200 diseases and conditions, including various cancers, neuropsychiatric disorders, cardiovascular diseases, mental health conditions, injuries, liver cirrhosis and several infectious diseases *(3)*. In fact, even light to moderate drinking has a significant impact on the burden of cancer *(4)*. Beyond direct health impacts, alcohol fuels interpersonal violence, child maltreatment and other harms that affect families and communities *(5)*. Adolescent alcohol use harms brain development and can result in learning difficulties, increased impulsivity, risky sexual practices and violence *(6−9)*. Nevertheless, alcohol use continues to be widely accepted and its harmful impacts frequently overlooked.

The draft, *Accelerating Implementation of the WHO Global Alcohol Action Plan 2022−2030 in the Western Pacific Region*, outlines alcohol consumption trends in the Western Pacific Region, highlights evidence on alcohol-attributable harms and calls on Member States to accelerate the implementation of the WHO *Global alcohol action plan 2022–2030*, which aims to achieve a 20% relative reduction in per capita alcohol consumption (APC)[1] by 2030 (from the 2010 baseline). This implementation plan is aligned with the Region's vision, *Weaving Health for Families, Communities and Societies in the Western Pacific Region (2025−2029)* and the *Regional Action Framework for Noncommunicable Disease Prevention and Control in the Western Pacific*, endorsed by the Regional Committee for the Western Pacific in 2022.

[1] APC is considered the most accurate and precise indicator of alcohol exposure in the population and cannot be calculated from population surveys. APC includes recorded, unrecorded and tourist consumption, and is derived from multiple sources, including sales and taxation data provided by governments and commercial operators.

Alcohol consumption and harm in the Western Pacific Region

Alcohol consumption remains high in the Western Pacific Region, influenced by factors such as increased affordability due to economic growth, aggressive marketing practices, easy availability, cultural and social acceptance, and weak regulatory frameworks and enforcement.

Rising levels of alcohol consumption are directly linked to higher risks of illness and mortality *(1)*. Some countries in the Region have among the world's highest consumption rates. Despite declines in China − home to over 70% of the Region's population − regional average consumption continued to be above the global average.

According to WHO's *World Health Statistic 2022*:

- In 2022, per capita alcohol consumption was 5.2 litres (L) in the Western Pacific Region compared to the global average of 5.0 L.[2]
- Some countries had significantly higher consumption – such as Cook Islands (14.9 L),[3] Australia (11.2 L), the Lao People's Democratic Republic (11.2 L), Viet Nam (10.7 L) and New Zealand (9.2 L).
- From 2000 to 2022, three out of the five countries in the world with the greatest absolute increase in APC were in the Western Pacific Region – Cambodia, Mongolia and Viet Nam. From 2010 to 2022, APC continued to increase significantly in Cambodia, the Lao People's Democratic Republic and Viet Nam. These increases likely have been driven by rapid economic transitions, coupled with weak regulation and aggressive marketing by the alcohol industry *(10)*.
- Unrecorded alcohol[4] – alcohol that is outside the system of government control, such as homemade or informally produced varieties – accounts for about 21% of total consumption, requiring specific interventions.

[2] At the time of data analysis, Indonesia was not yet a Member State of the WHO Western Pacific Region; therefore, its alcohol data are not included in the Background section. However, Indonesia is included in the monitoring and evaluation table, where specific alcohol policy baseline data are presented to enable progress tracking over the next five years.

[3] APC data from Cook Islands are from 2019, as 2022 data were not available.

[4] Unrecorded alcohol refers to alcohol that is not taxed and is outside the usual system of governmental 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 (which is recorded in a different jurisdiction).

Heavy episodic drinking (HED) is widespread in the Western Pacific Region, especially among youth, and rates among girls and young women are rising to match those of boys and young men.

HED is defined as consuming at least 60 grams of pure alcohol on one occasion at least once in the past month. In the Western Pacific Region, adolescent drinking patterns mirror adult behaviours in some countries, with increasing heavy consumption among youth.

According to the 2024 global status report:

- HED rates in the Western Pacific (19.1%) exceed the global average (16.7%) in 2019.
- Over one third (36%) of 15- to 19-year-olds drank in 2019, and 41% of young drinkers engage in HED.
- Rates of binge drinking among younger women are rising to levels comparable to their male peers.

Alcohol consumption is a leading cause of death and disability, with a rising burden in some Western Pacific countries, disproportionally affecting young people.

According to the 2024 global status report:

- Alcohol use caused one death nearly every minute in the Region in 2019, for a total of 485 424 or 3.5% of all deaths. Major alcohol-related causes included haemorrhagic stroke, liver cirrhosis and road injuries.
- Alcohol is a Group 1 carcinogen that is causally linked to seven types of cancer, including oesophageal, liver, colorectal and breast cancers *(4)*. In 2019, there were 131 000 cancer deaths attributed to alcohol, mainly from oesophageal cancer, colon and rectum cancers, and liver cancer.
- Among men aged 20−29, one in five deaths was attributable to alcohol.
- Alcohol accounted for 4.4% of all disability-adjusted life years (DALYs), including 16.2 million years lost to premature mortality. Some countries are experiencing increasing alcohol-related disease burdens.
- Women, youth, and economically disadvantaged and Indigenous populations bear a disproportionate burden of alcohol's harms, deepening inequities and social and economic vulnerabilities *(11, 12)*.

The COVID-19 pandemic significantly affected global alcohol consumption, with per capita intake dropping by 10.1% from 5.5 L in 2019 to 4.9 L in 2020. In the Western Pacific Region, the

decline was sharper – 16.4% from 6.1 L to 5.1 L. While overall use fell, particularly among young adults due to venue closures, heavy drinkers and those with mental health conditions increased their consumption. Survey limitations and industry forecasts suggest the overall decline may be temporary, with alcohol sales and per capita consumption expected to rebound to pre-pandemic levels by 2023 – along with related health and social costs, which currently account for 2.6% of global gross domestic product *(13)*. This underscores the urgent need to accelerate implementation of high-impact SAFER interventions[5] in the Western Pacific to turn short-term reductions into sustained declines in alcohol harm.

2. PLAN OF WORK

The *Global alcohol action plan 2022–2030* calls for strong national governance through multisectoral coordination to reduce alcohol-related harm, coordinated by high-impact strategies and interventions that tackle the acceptability, availability and affordability of alcohol. It emphasizes the need for a whole-of-government approach to ensure policy coherence and shield alcohol policy development from industry influence. The most impactful interventions are highlighted in WHO best buys − a set of cost-effective, evidence-based policy interventions to prevent and control noncommunicable diseases (NCDs). In addition, WHO's SAFER initiative outlines strategies to reduce alcohol-related harm. The combination of proven policies and implementation efforts aligned across sectors will reduce alcohol-related harm and costs, mitigate alcohol-related inequalities and accelerate progress towards the Sustainable Development Goals.

The Global Alcohol Action Plan sets a target for 70% of countries to have introduced, enacted or maintained the implementation of high-impact policy options and interventions by 2030. There has been significant progress. The 2024 global status report shows that Western Pacific Member States have significantly expanded adoption of WHO alcohol policies: nearly all now impose excise duties on at least one beverage category; the majority have set a minimum legal purchase age at 18 years or older; and a significant number have enacted drink–driving laws with blood alcohol concentration (BAC) limits of 0.05 grams per decilitre (g/dL) or lower, accompanied by enhanced routine enforcement. Additionally, a growing number of countries have introduced or reinforced marketing restrictions – especially on broadcast and outdoor media – and have begun integrating screening and brief interventions for at-risk drinkers into services for primary health care (PHC). Despite these gains, the

[5] SAFER was developed to meet global, regional and country health and development goals, and to reduce human suffering and pain caused by the harmful use of alcohol. The SAFER interventions are: Strengthen restrictions on alcohol availability; Advance and enforce drink−driving countermeasures; Facilitate access to screening, brief interventions and treatment; Enforce bans and comprehensive restrictions on alcohol advertising, sponsorship and promotion; Raise prices on alcohol through excise taxes and other pricing policies.

report underscores uneven implementation, with gaps remaining in full coverage of marketing bans, enforcement strength and health-system capacity. The *Noncommunicable diseases: Progress monitor 2025* showed that only one country in the Western Pacific Region has implemented all three best-buy measures. Intensified efforts are needed to close these gaps. The Pacific Monitoring Alliance for NCD Action (MANA) *Pacific Data Hub – MANA Dashboard* also shows that virtually all Pacific island countries and territories have now established three foundational alcohol control measures – alcohol licensing to restrict sales, excise taxation and drink–driving laws. However, the MANA Dashboard also spotlights uneven gains on advertising bans, with only eight of 21 countries and territories green-lighted for some alcohol advertising regulations, indicating clear opportunities to strengthen comprehensive marketing restrictions across the Pacific region.

Accelerating and scaling up policy adoption and enforcement are essential to curb alcohol consumption and associated health risks and social costs, and thus constitute the priority actions of this plan of work. These actions are underpinned by action areas 2−6 of the Global Alcohol Action Plan: Advocacy, awareness and commitment; Partnership, dialogue and coordination; Technical support and capacity-building; Knowledge production and information systems; and Resource mobilization. These are woven throughout the detailed recommendations and the Implementation Road Map. Raising public awareness about alcohol harms and the benefits of effective alcohol control policies alongside policy implementation is especially vital, as informed communities drive social norms, bolster political commitment and create the mandate needed to adopt and sustain all SAFER measures, and is thus included as a priority action.

Member States are urged to implement the following priority actions:

1 **Reduce alcohol affordability.** Increase excise taxes on alcoholic beverages and adjust them for inflation and income growth to sustain the reduction in affordability.

2. **Reduce alcohol availability.** Enforce age restrictions; regulate sales hours, outlet density, and online sales and home delivery; and strengthen licensing systems with community involvement to prevent easy access to alcohol.

3. **Ban or comprehensively restrict alcohol marketing.** Ban or comprehensively restrict alcohol advertising, sponsorship and promotion across all media channels – including digital and social media. Such measures can shift social norms around alcohol use and protect young people and those who abstain.

4. **Implement drink–driving policies and countermeasures.** Enforce strong drink–driving laws and low BAC limits via sobriety checkpoints and random breath testing (RBT) to save lives from alcohol-related road crashes.

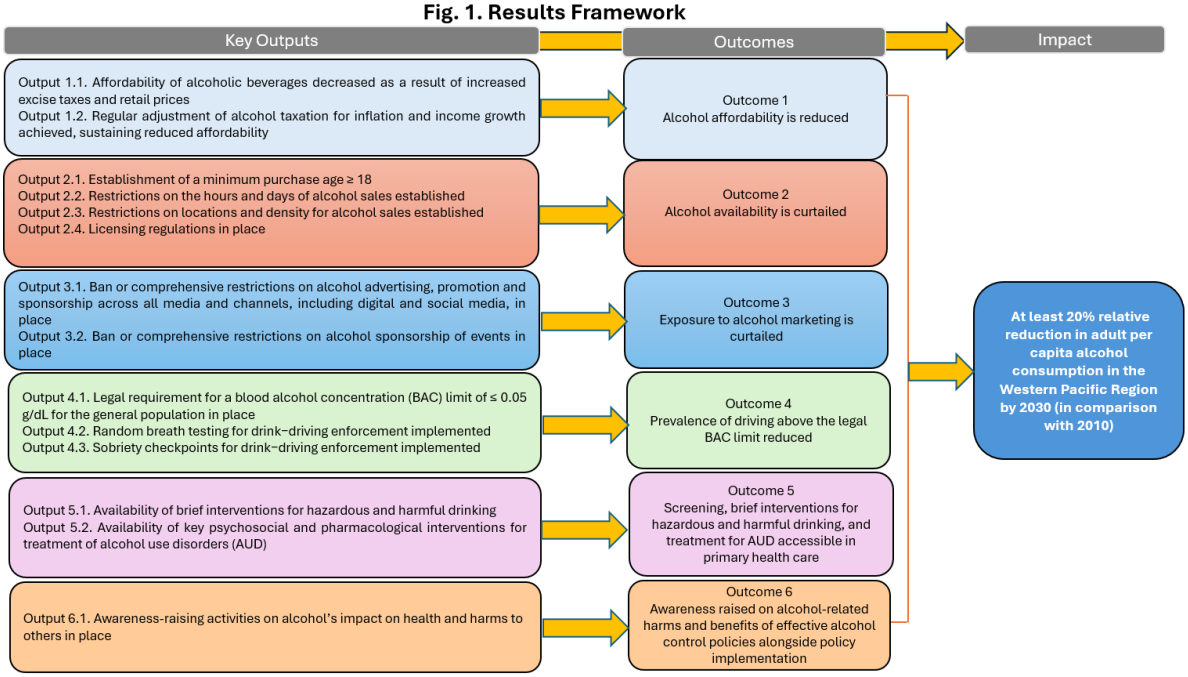
5. **Increase the coverage and quality of screening and brief interventions for hazardous and harmful drinking, and ensure access to treatment for alcohol use disorders (AUD).** Integrate screening and brief interventions into PHC, support peer and family recovery networks, address stigma and ensure access to treatment.

6. **Raise awareness among the general public about alcohol harms and the benefits of effective alcohol control policies.** Build public understanding and support through education campaigns, media and community engagement, and leadership by example.

Detailed recommendations for implementing the priority actions can be found in the Annex.

Fig. 1 presents the Results Framework for this plan of work, showing how the key outputs of the recommended activities feed into the outcomes of the six priority actions, ultimately driving the 20% reduction in adult per capita alcohol consumption in the Western Pacific by 2030. This visual model also underpins the detailed monitoring and evaluation table (Table 1) in the Monitoring and Evaluation section of this document.

Fig. 1. Results Framework



3. IMPLEMENTATION ROAD MAP

Countries in the Western Pacific Region are at different stages of developing and implementing alcohol control policies. This Implementation Road Map offers a step-by-step pathway for Member States to translate their commitments into concrete action − no matter where they currently stand. It guides them through a flexible seven-step cycle with embedded cross-cutting enablers, under four connected phases:

- Diagnose
  - Step 1. Conduct situational assessment and define core metrics
- Galvanize
  - Step 2. Raise awareness and political commitment
  - Step 3. Identify strategic allies and entry points
  - Step 4. Secure early wins to build momentum
- Scale
  - Step 5. Strengthen implementation and enforcement
  - Step 6. Scale and consolidate
- Sustain
  - Step 7. Monitor, evaluate and adapt

Although these steps are shown in sequence, countries may overlap phases and steps and loop back as new data and opportunities arise − for example, revisiting the Diagnose phase whenever insights emerge from pilots or enforcement reviews. Activities in Steps 2–4 also can proceed in parallel when political windows emerge or capacity allows, and lessons from early legislative wins or peer-learning events should feed back into priority-setting, ensuring the Road Map continually adapts to each country's evolving context.

DIAGNOSE (Step 1)

Step 1. Conduct situational assessment and define priority actions and core metrics

Before taking any action, conduct a situational assessment to identify priority actions and determine entry points in the Implementation Road Map. Using Table 1 as a reference, identify a concise set of core performance and outcome metrics that will later feed into the monitoring framework

− for example, reduced affordability of alcoholic beverages, percentage increase in availability of screening and brief intervention services at PHC settings, or reduction in alcohol advertising on the social media. To inform action, it is necessary to gather data on:

- Consumption − including alcohol consumption per capita, alcohol prevalence, HED, youth use and unrecorded or home-brewed alcohol.
- Health and social burden − including alcohol-attributable DALYs and mortality, injuries, violence and NCDs.
- Policy landscape − including alignment with SAFER best buys, and gaps in legislation, regulation and enforcement.
- Political and system readiness − including enabling national priorities, presence of influential individuals who can champion the issue, institutional capacity and coordination mechanisms, and opportunities and risks, including degree of industry influence.

By the end of this step, countries and areas in the Region should be able to gauge where to begin and which measures to prioritize. In contexts where alcohol control measures are absent or have yet to take root, Steps 2–4, which are detailed below, can provide the foundation for policy development.

GALVANIZE (Steps 2–4)

Step 2. Raise awareness and political commitment

- Reframe alcohol control as a development issue and align it with domestic development goals.
- Embed an equity lens by highlighting how alcohol harms youth, women, and Indigenous and low-income communities.
- Quantify health, social and economic harms.
- Launch targeted communications campaigns to build public support and political will.
- Secure high-level endorsements (for example, cabinet decisions and parliamentary motions).
- Anticipate and prepare for industry pushback.

Step 3. Identify strategic allies and entry points

- Engage champions across health, transport, finance, education and civil society.

- Leverage non-health platforms, such as road safety coalitions and gender-equity initiatives.
- Map out programmes and sectors for integration of alcohol measures.

Step 4. Secure early wins to build momentum

- Select feasible and high-impact measures (for example, a modest excise tax increase and strict enforcement of minimum-age purchase laws) that offer clear benefits and build momentum for broader, systemic change.
- Pilot one or two local interventions for a clear demonstration of results.
- Showcase results via press briefings, social media and stakeholder forums to highlight tangible gains.
- Leverage early wins to attract additional budget lines, technical assistance and fresh champions across sectors.

As countries begin to see tangible results from these early efforts, Steps 5–6 naturally transition the focus towards deepening impact − by strengthening legislative frameworks, bolstering enforcement mechanisms and institutionalizing coordination and monitoring systems.

SCALE (Steps 5–6)

Step 5. Strengthen implementation and enforcement

- Close legal loopholes and tighten regulations on marketing, pricing and access.
- Train enforcement officers, health workers and community actors.
- Deploy digital tools for real-time monitoring, compliance checks and data collection.

Step 6. Scale and consolidate

- Roll out proven interventions in areas beyond the pilot site.
- Formalize coordination mechanisms at national and subnational levels.
- Strengthen capacity-building through refresher trainings and peer-learning networks, as well as knowledge management systems.

Once foundational policies are established, governments can progress smoothly to consolidating and expanding implementation for lasting, sustainable change.

SUSTAIN (Step 7)

Step 7. Monitor, evaluate and adapt

- Validate the core performance and outcome metrics defined at the outset (or in Step 1) and integrate them into the monitoring framework.
- Maintain reliable, timely collection of both quantitative data (for example, policy compliance rates, tax revenue changes) and qualitative data (for example, stakeholder feedback).
- Conduct periodic reviews combining survey results, focus group insights and administrative data analysis to assess progress against targets.
- Feed insights back into Steps 2–6 to fine-tune priorities, adjust interventions and reinforce what is working.
- Report regularly against the agreed monitoring and evaluation framework, ensuring each country submits data on all key indicators, discusses gaps and successes in regional and national forums, and takes corrective action to address underperforming areas.

Overarching approach: Embed cross-cutting enablers throughout all steps

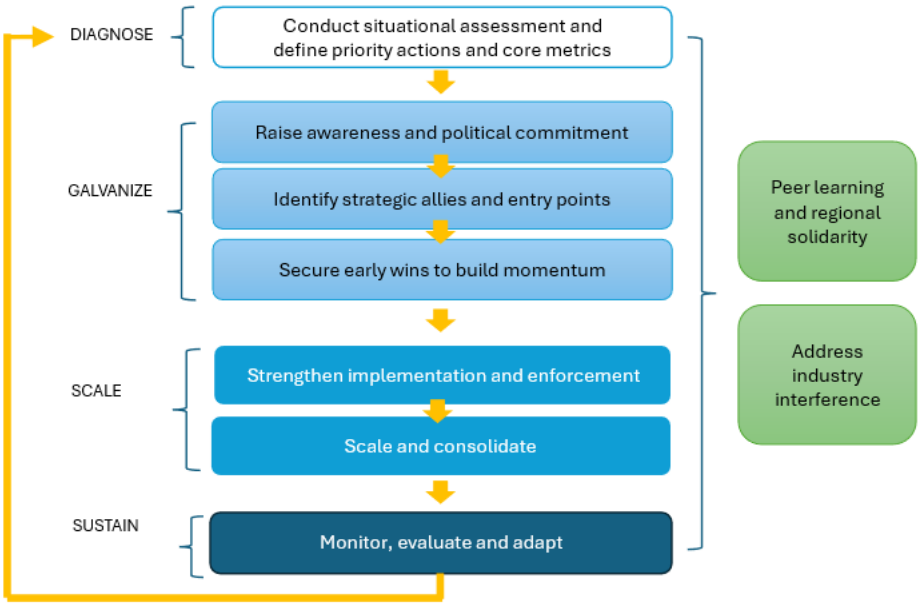
The following two actions are woven through all four phases of the Implementation Road Map to ensure that progress is resilient, collaborative and protected from vested interests. By embedding them from diagnosis (Step 1) through monitoring and evaluation (Step 7), countries can accelerate learning, share resources and safeguard policy integrity.

The two actions are:

Peer learning and regional solidarity – which fosters continuous knowledge exchange through study visits, case studies, thematic workshops and shared toolkits so that successes in one context can be adapted and scaled across the Region.

Protection from industry interference – which requires establishing transparency measures or conflict-of-interest policies. Stakeholders should be trained to recognize and counter industry tactics, and civil society organizations should be empowered to advocate for evidence-based policies free from industry interference. Fig. 2 is a visual representation of the Implementation Road Map.

Fig. 2. Implementation Road Map



4. ACCELERATION PROJECTS TO IMPLEMENT THE WHO GLOBAL ALCOHOL ACTION PLAN 2022–2030

The Implementation Road Map offers a flexible, step-by-step approach for Member States to develop and scale alcohol control policies. To complement this approach, the set of Acceleration Projects detailed below can help fast-track progress in areas where support is most needed. These projects are not stand-alone initiatives − they are designed to unlock synergies across national priorities, such as strengthening PHC, advancing universal health coverage (UHC) and accelerating NCD prevention and control. Aligned with the regional vision and the Global Alcohol Action Plan, the Acceleration Projects provide practical, high-impact entry points that integrate alcohol control into broader health and development agendas and help countries translate the Implementation Road Map into real-world action.

Acceleration Project 1. Integrate alcohol control into national NCD prevention strategies

- Explicitly embed alcohol control within national policies that tackle NCD risk factors so that they can be addressed synergistically.
- Reduce the affordability of alcohol by imposing and increasing excise taxes, along with fiscal strategies for other unhealthy and harmful products, using a comprehensive regulatory framework to reduce their affordability. Allocate part of the revenue to NCD prevention, health promotion or health services.

- Establish a common and consistent regulatory framework that enforces marketing bans or comprehensive restrictions on alcohol, protecting youth and vulnerable groups by aligning with similar regulations for tobacco, unhealthy foods and other products that harm health.
- Coordinate the use of digital tools to monitor and restrict online marketing of all harmful products, ensuring consistent protection for all population groups.

Acceleration Project 2. Develop health workforce solutions

- Strengthen health workforce capacity to deliver alcohol screening, provide brief interventions, refer people to appropriate services and support treatment for AUD.
- Incorporate training on brief interventions, behavioural counselling, peer-to-peer group sessions related to alcohol control and motivational interviewing into curricula for medical, nursing and community health workers.
- Develop continuous professional development programmes for health-care workers on screening and brief interventions for AUD.

Acceleration Project 3. Institutionalize brief advice in PHC practice

- Develop and implement a PHC protocol to screen patients for hazardous or harmful alcohol use and provide brief interventions − such as, counselling and advice − to reduce consumption as part of routine PHC services.
- Integrate recommended alcohol prevention and treatment services into UHC benefit package schemes, including access to evidence-based psychosocial and pharmacological interventions.
- Leverage digital tools, such as electronic medical records or mobile apps, to prompt PHC workers to conduct brief NCD risk counselling and support continued patient engagement.
- Develop clear national referral systems linking PHC with specialized AUD treatment centres.

Acceleration Project 4. Incorporate alcohol control interventions into Healthy Settings initiatives

- In relation to the Healthy Cities initiative, advocate for alcohol control policies, such as regulating alcohol outlet density and locations, restricting days and hours of alcohol sales, enforcing zoning and licensing regulations, and establishing alcohol-free zones.
- Prohibit alcohol use in public spaces, schools and workplaces, similar to prohibitions on tobacco use in tobacco-free initiatives.

- Implement measures such as embedding combined alcohol–suicide risk checks into routine school health visits, as appropriate, to facilitate early identification of at-risk young people. Train teachers, school counsellors and community leaders to use simple tools and deliver brief advice or referral.
- Engage schools, workplaces, and community- and faith-based organizations – including people with lived experience of alcohol harm – in co-designing and delivering culturally relevant initiatives and in raising awareness of the harms of alcohol use and challenging drinking norms.

5. MONITORING AND EVALUATION

Progress in reducing alcohol use and related harms should be assessed against the global target of achieving a 20% relative reduction in the harmful use of alcohol by 2030, compared to the 2010 baseline. The Global Alcohol Action Plan also sets a target for 70% of countries to have introduced, enacted or maintained the implementation of high-impact policy options and interventions by 2030.

To track progress, key indicators from the priority actions (high-impact interventions) from the Global Information System on Alcohol and Health (GISAH) are included in Table 1, along with the number of countries expected to meet the 2027 benchmark targets (midterm milestones) and the 2030 targets. The 2025 baseline was drawn from the latest data available through the WHO Global Health Observatory online database, including data from GISAH. The 2027 benchmark targets and 2030 targets were determined by reviewing the 2025 baselines for each indicator and applying an ambitious but realistic growth trajectory, tailored to the current level of uptake:

- High baseline (> 50% coverage in 2025): Aim for near-universal adoption by 2030 (80–90% of countries). Set a smaller absolute gain between 2025–2027 (10–15%), with larger growth from 2027 to 2030 as alignment and enforcement consolidate.
- Moderate baseline (25–50%): Maintain steady momentum with 20–25% growth in each period, supported by technical assistance, cross-country exchange and peer learning.
- Low baseline (< 25%): Recognizing that limited uptake often reflects low political support, strong alcohol industry interference and feasibility challenges, the focus is on building enabling conditions through advocacy, coalition-building and technical support. Where readiness exists, aim for 20–30% growth from 2025 to 2027 to generate momentum, then 15–20% from 2027 to 2030 to consolidate and expand progress.

The WHO Secretariat will continue collaborating with Member States to refine and validate these indicators and strengthen monitoring systems. A progress report on the implementation of the recommended actions will be submitted to the WHO Regional Committee for the Western Pacific in

2027, with recommendations for 2028–2030. These will align with the Global Alcohol Action Plan to support the effective implementation of WHO's *Global strategy to reduce the harmful use of alcohol* as a public health priority.

Table 1. Monitoring and Evaluation Framework

Indicator	Baseline	2027 targets	2030 targets
At least 20% relative reduction in adult per capita alcohol consumption in the Western Pacific Region by 2030, compared with 2010 levels			
Alcohol per capita consumption (L)	6.1 (2010) 5.2 (2022)	5.1	4.9
Outcome 1: Alcohol affordability is reduced			
Output 1.1: Affordability of alcoholic beverages decreased as a result of increased excise taxes and retail prices			
Number of countries with reduced affordability of alcoholic beverages	Data to become available by end of 2025	30% increase from 2025	20% increase from 2027
Output 1.2: Regular adjustment of alcohol taxation for inflation and income growth achieved, sustaining reduced affordability			
Number of countries with automatic adjustment of their specific excise tax	4	10	14
Outcome 2: Alcohol availability is curtailed			
Output 2.1: Establishment of a minimum purchase age ≥ 18			
Number of countries with a minimum legal age of 18 years or older for **on-premise** alcohol service	19	22	24
Number of countries with a minimum legal age of 18 years or older for **off-premise** alcohol sales	16	19	22
Output 2.2: Restrictions on the hours and days of alcohol sales established			
Number of countries with legal restrictions on hours of **on-premise** alcohol sales	13	18	24
Number of countries with legal restrictions on hours of **off-premise** alcohol sales	10	16	21
Number of countries with legal restrictions on days of **on-premise** alcohol sales	11	17	22
Number of countries with legal restrictions on days of **off-premise** alcohol sales	7	13	18
Output 2.3: Restrictions on locations and density for alcohol sales established			
Number of countries with legal restrictions on locations of **on-premise** alcohol sales	15	18	22
Number of countries with legal restrictions on locations of **off-premise** alcohol sales	12	18	23
Number of countries with legal restrictions on the density of **on-premise** alcohol sales	6 (including one with exemption for beer)	12	16
Number of countries with legal restrictions on the density of **off-premise** alcohol sales	2	8	12
Output 2.4: Licensing regulations in place			
Number of countries requiring licence for retail sales	15	18	22

Indicator	Baseline	2027 targets	2030 targets
Number of countries with regulations on remote ordering of alcohol	6 on-premise; 4 off-premise	16	21
Outcome 3: Exposure to alcohol marketing is curtailed			
Output 3.1: Ban or comprehensive restrictions on alcohol advertising, promotion and sponsorship across all media and channels, including digital and social media, in place			
Number of countries with a ban or comprehensive restrictions on alcohol advertising on billboards	1 (3 partial)	6	11
Number of countries with a ban or comprehensive restrictions on national television	3 (6 partial)	9	11
Number of countries with a ban or comprehensive restrictions on alcohol advertising in print media	1 (6 partial)	6	11
Number of countries with a ban or comprehensive restrictions on alcohol advertising on the internet	1 (3 partial)	6	11
Number of countries with a ban or comprehensive restrictions on alcohol advertising on social media	1 (2 partial)	6	11
Output 3.2: Ban or comprehensive restrictions on alcohol sponsorship of events in place			
Number of countries with a ban or comprehensive restriction on alcohol sponsorship of sporting events	2 (5 partial)	8	12
Number of countries with a ban or comprehensive restrictions on alcohol sponsorship of youth events	1 (2 partial)	6	11
Outcome 4: Prevalence of driving above the legal blood alcohol concentration (BAC) limit reduced			
Output 4.1: Legal requirement for a BAC limit of ≤ 0.05 g/dL for the general population in place			
Number of countries with a BAC limit of ≤ 0.05 g/dL for the general population	11	17	22
Output 4.2: Random breath testing (RBT) for drink-driving enforcement implemented			
Number of countries reporting implementation of RBT	15	18	23
Output 4.3: Sobriety checkpoints for drink-driving enforcement implemented			
Number of countries with sobriety checkpoints for drink–driving enforcement	13	18	24
Outcome 5: Screening, brief interventions for hazardous and harmful drinking, and treatment for alcohol use disorders (AUD) accessible in primary health care			
Output 5.1: Availability of brief interventions for hazardous and harmful drinking			
Number of countries with screening and brief intervention programmes for AUD	13	18	24
Output 5.2: Availability of key psychosocial and pharmacological interventions for treatment of AUD			
Number of countries with pharmacological treatment for AUD	13	18	24
Number of countries with psychosocial interventions for treatment of AUD	7	13	18
Outcome 6: Awareness raised on alcohol-related harms and benefits of effective alcohol control policies alongside policy implementation			
Output 6.1: Awareness-raising activities on alcohol's impact on health and harms to others in place			
Number of countries with awareness-raising activities on alcohol's impact on health and harms to others	15	18	22

6. ROLE OF THE WHO SECRETARIAT

WHO in the Western Pacific Region will support Member States to implement the following key actions:

6.1 Supporting policy development, regulation and implementation

- Assist in policy development by providing global evidence and guidance adaptable to national and local contexts.
- Support Member States in protecting alcohol policy development from conflicts of interest and industry interference to ensure policies are based on public health evidence.
- Aid in policy implementation by addressing weak monitoring and compliance mechanisms, as well as industry interference.
- Assist Member States in identifying, monitoring, exposing and countering alcohol industry interference throughout the entire policy cycle, including implementation and enforcement.
- Enhance national capacities and governance to design, implement, monitor and enforce effective national and subnational alcohol policies and services.

6.2 Facilitating multisectoral collaboration and community engagement

- Facilitate dialogue and engagement with various government sectors to advocate for public health-oriented alcohol policies.
- Work with governments and civil society to raise awareness of alcohol harms, counter misinformation and build support for evidence-based policies.
- Support Member State community initiatives to promote alcohol policies and regulations and reduce alcohol harm.

6.3 Enhancing data monitoring and surveillance

- Support the generation of national and regional evidence and ensure evidence-based decision-making.
- Integrate alcohol metrics into routine health management information systems and surveillance by embedding alcohol-specific modules and harmonizing data elements, for example, linking emergency-department injury registries to alcohol screening results.

- Provide tools and technical assistance to support Member States in monitoring alcohol consumption, related harms and policy implementation, while evaluating progress and impact.

6.4 Strengthening regional coordination and knowledge-sharing

- Collect and disseminate effective administrative, regulatory and legislative strategies for alcohol control.
- Promote inter-country cooperation by facilitating the sharing of experiences among countries through workshops, technical briefings and inter-country exchange and cooperation initiatives.

7. CONCLUSION

Alcohol-related harm remains a major public health and development challenge in the Western Pacific Region. The evidence is unequivocal: alcohol contributes significantly to mortality, morbidity, injuries, violence and health inequities − particularly among youth, women and marginalized populations. Despite progress in some countries and areas, implementation gaps persist, and in many parts of the Region alcohol remains relatively affordable, widely available and aggressively marketed.

This regional plan is intended to support and accelerate implementation of the WHO *Global alcohol action plan 2022–2030* across the Western Pacific. Grounded in the SAFER technical package and aligned with the Region's vision of *Weaving Health for Families, Communities and Societies in the Western Pacific (2025–2029)*, it provides Member States with a structured yet flexible Implementation Road Map and a set of Acceleration Projects. By leveraging synergies across key priorities − such as NCD prevention, UHC and transformative PHC − countries and areas can achieve a broader impact on public health. The Acceleration Projects in particular offer practical entry points to embed alcohol control into health systems, fiscal policies and community settings.

Strong leadership, whole-of-government coordination and protection from industry interference will be essential to ensure reforms are equitable, sustained and aligned with public health goals. WHO will continue to support Member States in this work − providing technical assistance, facilitating multisectoral collaboration and fostering shared learning.

With collective action, the Western Pacific Region can reduce alcohol consumption and its related harms, contributing to a healthier, more equitable future for all.

ANNEX

Priority actions for the draft *Accelerating Implementation of the WHO Global Alcohol Action Plan 2022–2030 in the Western Pacific Region*

1. Reduce alcohol affordability

Evidence indicates that higher alcohol excise taxation reduces alcohol-attributable mortality *(14)*. Alcohol consumption by young people is strongly influenced by price, with increased prices leading to reduced consumption *(15)* and subsequently decreasing rates of suicide, traffic injuries and sexually transmitted diseases. Increasing prices on alcohol through excise taxes and other fiscal measures is considered the most cost-effective intervention *(15)*. In addition, alcohol taxes can raise revenue and address the financing gap to promote achievement of the Sustainable Development Goals *(16)*.

In the Philippines, excise tax reforms have demonstrated what is possible. Between 2017 and 2021, stronger alcohol taxes helped boost health-tax revenue from approximately US$ 3.3 billion in 2017 to US$ 4.7 billion in 2021, with a substantial portion allocated to health initiatives. Economic modelling suggests that every US$ 1 invested in alcohol control returns about US$ 1.50 in avoided harm and associated costs over five years – and up to US$ 7 over 15 years *(17)*.

All countries in the Western Pacific Region levy an excise tax on at least one alcohol category. However, the Region has the lowest alcohol tax rates globally, making alcohol relatively affordable *(18)*. Excise taxes in the Region are usually not adjusted for inflation, and in most countries no portion of tax revenue is dedicated to prevention or treatment programmes.

Recommended actions:

- **Raise and index excise tax rates.** Increase alcohol excise taxes and annually adjust excise rates to both consumer-price inflation and per capita income growth, preventing real-value erosion and ensuring affordability declines over time.
- **Shift to a volumetric structure.** Base duties on ethanol content so that higher-strength products incur proportionally higher taxes.
- **Allocate alcohol tax to prevention or health services.** Dedicate a defined share of additional alcohol tax revenue for evidence-based prevention, early intervention and treatment services.
- **Strengthen enforcement against illicit alcohol.** Coordinate with ministries and stakeholders – using tax stamps, licensing, track-and-trace systems and inspections – to combat untaxed production and informal markets.

- **Enhance multisectoral partnership.** Establish a multisectoral fiscal-health working group – spanning the ministries of health, finance and trade – to co-design, enact and monitor evidence-based alcohol excise taxation policies.
- **Harmonize regional fiscal measures.** Collaborate with neighbouring countries to harmonize fiscal measures and avoid price differentials that generate illicit marketing of alcoholic beverages.

2. Reduce alcohol availability

Alcohol availability refers to how easily people can obtain alcoholic beverages. Increased availability is linked to higher rates of consumption, which can lead to greater incidences of alcohol-related harm. Most countries in the Region have licensing systems, but weak or non-existent regulations and poor enforcement on sales hours, outlet density and locations, online purchases, and home delivery make alcohol widely available in urban centres and smaller islands.

Key measures to limit availability include enforcing a legal minimum age for purchases and consumption, and regulating sales hours, outlet location and density, online sales and home delivery. Strengthening licensing systems with community involvement can help mitigate harm and promote safer environments. The latest evidence shows that parents supplying alcohol to young people increases the risk of heavy consumption and harm in later life, highlighting the role of families in reducing availability *(19)*.

Samoa's Alcohol Control Act 2020 establishes a licensing system for alcohol retail sales, sets the minimum age for purchase at 21, restricts sales hours and days, and limits alcohol consumption in certain public areas to maintain public order and safety. Violations can result in fines, imprisonment or both *(3, 20)*.

Recommended actions:

- **Enforce minimum age for alcohol purchase and consumption.** Build on enforcement of existing age-limit laws (18 years and over in most countries) through regular compliance checks, including "secret shopper" initiatives in partnership with civil society organizations. Apply clear legal penalties for violations, and conduct awareness campaigns to inform retailers and communities about the law.
- **Upgrade licensing and limit outlet density.** Strengthen licensing systems for the production and distribution of alcoholic beverages. Upgrade all current licences – on-licence, off-licence and remote-sales permits – to include outlet-density caps (for example, maximum of one off-

licence per 1000 residents). Geographic Information Systems mapping tools can help municipal councils roll out licensing systems in cohorts.

- **Engage communities in licensing decisions.** Formalize local alcohol impact committees that include representatives from health, law enforcement, local government and civil society to vet new and renewal applications, with particular attention to disadvantaged neighbourhoods.
- **Limit sales hours and days.** Enact legally binding restrictions on hours and days of sale, integrate these measures into licensing regulations and monitor compliance. Progressively shorten trading hours and monitor the impact on alcohol harm.
- **Prohibit service to intoxicated persons and public drinking.** Enact and enforce prohibitions on serving intoxicated individuals, as well as consumption in public places, backed by clear penalties and routine patrols in high-traffic public areas.
- **Regulate remote selling and home delivery.** Extend restrictions for physical retail outlets – minimum age checks, prohibition on serving intoxicated persons, and restrictions on days and hours of sale – to remote selling (online and telephone) and home deliveries. Mandate limits on order size and delivery windows (for example, a two-hour minimum period between order and receipt).
- **Launch community-driven campaigns.** Work with civil-society partners to mobilize public support and enable community-led monitoring of availability measures.
- **Integrate parental and family interventions.** Incorporate modules on the risks of alcohol use and early home supply into existing maternal and child health outreach. Train community health workers to deliver these modules during routine home visits and clinic appointments.

3. Ban or comprehensively restrict alcohol marketing

Alcohol marketing normalizes alcohol use, leading to earlier initiation, heavier consumption and greater harm, particularly among young people and vulnerable groups *(21)*. Alcohol marketing also undermines efforts to reduce consumption and dependence. Banning or comprehensively restricting marketing − including in digital media − and banning alcohol brand sponsorships of sports and cultural events can significantly reduce consumption and harm. Voluntary self-regulation of the alcohol industry has proven to be ineffective.

Though increasingly aggressive and exploitative, alcohol marketing practices in the Western Pacific Region remain largely unregulated – including digital marketing driven by AI that targets young people. Government efforts to regulate these channels have been insufficient.

Brunei Darussalam has implemented a comprehensive ban on alcohol advertising, promotion and sponsorship. The country also established public agencies for the surveillance of alcohol marketing. These agencies are responsible for monitoring compliance with the regulations and imposing penalties for violations. These steps, along with other policy interventions, have resulted in a sustained decrease in alcohol consumption and related harms *(22)*.

Recommended actions:

- **Prohibit alcohol marketing.** Review and amend existing communications or liquor-control laws to prohibit or comprehensively restrict alcohol advertising, promotion and sponsorship across all types of media (television, radio, print, cinemas, outdoor, online and social) and at public events.
- **Tie compliance to alcohol licensing and permits.** Make adherence to marketing restrictions a condition of brewery, importer and distributor licences, where non-compliance triggers fines, licence suspension or revocation.
- **Strengthen enforcement through digital and community monitoring.** Consider establishing an integrated monitoring system – combining web-scraping and social-media analytics with a "Report an Ad" SMS/WhatsApp hotline – so that, where feasible, flagged violations are investigated, ideally within 72 hours, with Member States adjusting this target as needed based on local capacity.
- **Engage civil society and media.** Partner with nongovernmental organizations, youth groups and journalists to raise awareness of alcohol marketing bans and encourage public reporting of violations.

4. Implement drink–driving policies and countermeasures

Alcohol significantly increases the risk of road traffic crashes, with injuries leading to 4.4 million disability-adjusted life years (DALYs) lost in the Western Pacific in 2019 *(23)*. Drink−driving laws and countermeasures, such as blood alcohol concentration (BAC) limits, are cost-efficient interventions. However, their success depends on robust enforcement infrastructure and implementation. Random breath testing (RBT), when combined with strict penalties and enforcement, is among the strongest deterrents to drink−driving. Other approaches include sobriety checkpoints, licence suspensions, ignition interlock devices, mandatory driver education, the provision of alternative transportation, counselling and treatment programmes for repeat offenders, and well-planned and executed media campaigns. Studies have indicated that the alcohol industry's participation in policy-

making may prioritize measures that have minimal impact on alcohol sales, potentially undermining public health objectives *(24)*.

In the Western Pacific Region, inconsistent enforcement has limited the impact of laws of many countries and areas on the legal BAC for drivers.

An example of success comes from Viet Nam, where a zero-tolerance drink–driving policy has been enforced through 2.75 million random breath checks, resulting in 262 000 violations, since 2020. This has led to a 29.7% reduction in alcohol-related road traffic crashes, a 43.2% decrease in injuries and a 28% reduction in fatalities since 2020.[6]

Recommended actions:

- **Set BAC limits.** Establish and enforce BAC limit at 0.05% or lower, with additional provisions for young, novice and professional drivers.
- **Enhance enforcement.** Collaborate with transport authorities and police to expand RBT and sobriety checkpoints in high-risk areas, and use digital platforms for reporting and inter-agency coordination.
- **Complement enforcement with awareness campaigns.** Implement evidence-based public education targeting alcohol-related road injuries and fatalities, with tailored messaging for high-risk groups.
- **Monitor alcohol-related injuries.** Monitor road traffic injuries related to alcohol consumption to assess policy impacts and identify necessary adjustments.

5. Increase the coverage and quality of screening and brief interventions for hazardous and harmful drinking, and ensure access to treatment for alcohol use disorder (AUD)

Brief interventions in health-care settings reduce alcohol-related harm, with health professionals supporting individuals to reduce consumption. As described in WHO's technical package for the SAFER initiative, early identification and counselling in primary care, emergency departments and reproductive health services have demonstrated benefits, particularly for women during pregnancy. Behavioural and pharmacological therapies, along with psychosocial interventions, also contribute to positive outcomes.

[6] Based on data compiled and reported by the Viet Nam Ministry of Public Security.

A study in the Republic of Korea demonstrates success, where brief counselling sessions in emergency rooms for injured patients with heavy drinking patterns or AUD led to significant reductions in alcohol consumption, particularly among those with severe disorders *(25)*.

Treatment options for AUD are poorly integrated into PHC and UHC systems in the Western Pacific Region. Cultural stigma and low recognition of mental health issues further hinder access to necessary treatments.

Recommended actions:

- **Ensure AUD treatment access.** Ensure affordable, universal access to AUD treatment and rehabilitation within national health systems, including access to key evidence-based psychosocial and pharmacological interventions in line with WHO guidance.
- **Provide alcohol screening and brief intervention services.** Embed the WHO AUDIT screening tool and brief advice protocol into routine checks at primary health care (PHC) settings and in other contexts based on evidence − for example, emergency departments and maternal health clinics, with on-site digital job aids such as tablets or smartphone apps, and referral algorithms to the nearest treatment and rehabilitation hub.
- **Build PHC workforce capacity.** Sustainably strengthen health workforce capacity to deliver alcohol screening and interventions. Enhance advocacy and quality assurance of screening and brief interventions for hazardous and harmful drinking, as well as facilitate access to treatment for people with alcohol dependence.
- **Educate health and social care workers.** Raise awareness among health and social care workers about alcohol risks and harms and ensure that alcohol is prioritized as a public health issue within health-care systems.
- **Integrate with mental health and community supports.** Link alcohol prevention, treatment and rehabilitation services with accessible mental health care, trauma-informed counselling and community-based support that promote healthy coping strategies, provide culturally appropriate care, and ensure a continuum of care from prevention through recovery.
- **Support peer and family recovery groups.** Support self-help and mutual-aid organizations − such as Alcoholics Anonymous − in communities to aid recovery and strengthen family members' understanding of AUD.

6. Raise awareness among the general public about alcohol harms

Awareness-raising − including building awareness among journalists and influencers in the media − can increase understanding among consumers of the risks of alcohol, helping to correct low public awareness of links to cancer, fetal alcohol spectrum disorders and other harms, and complementing marketing restrictions and SAFER or best-buy measures.

In the Western Pacific Region, public discourse on alcohol harms and policy remains sparse and inconsistent. Health professionals and civil society can assist ministries of health to take opportunities provided by new data to increase awareness. Increased awareness of alcohol's causal role in cancer has been shown to increase support for effective policies.

Recommended actions:

- **Carry out awareness campaigns.** Design and implement sustained, evidence-based public education campaigns that raise awareness of alcohol-related harms and build support for policy measures – ensuring these efforts complement, rather than replace, the implementation of effective alcohol control policies. Embed alcohol harm-reduction messages across schools, workplaces, faith-based gatherings, primary care clinics and other community settings.
- **Engage multisectoral partners.** Forge multisectoral partnerships (education, youth affairs, trade, law enforcement and civil society) to amplify awareness of alcohol policy and its positive effect, to reduce harm through community events, sports and cultural platforms, and social-norming initiatives, all under strict rules to prevent conflicts of interest.
- **Model leadership.** Ban use of public funds to buy or consume alcohol, and prohibit public officials from consuming on the job or at work events.

No single policy is sufficient on its own, and the greatest health gains come from implementing the full package of evidence-based measures embodied in the SAFER initiative. Meanwhile, governments can seize political windows of opportunity to introduce any feasible policy – whether it is raising excise taxes, enacting marketing restrictions, limiting hours or days of sale, tightening drink–driving laws or integrating brief interventions into primary care – and use each early win to build public and political support for the next measure. By stepping up one best buy at a time, countries can achieve immediate health gains, demonstrate policy effectiveness and generate the momentum needed to progressively implement the complete SAFER package and drive sustained reductions in alcohol-related harm.

WHO has documented several national experiences where comprehensive alcohol control policies have led to measurable public health gains. For example, Lithuania has transformed one of

Europe's highest alcohol-attributable mortality rates into a sustained decline – achieving a 36% reduction in alcohol-attributable years of life lost between 2010 and 2019 – through a comprehensive package of best-buy interventions. Beginning in 2007, the country phased in steep excise tax increases – for instance, a greater than 100% increase in excise taxation for beer and wine in 2017, plus a 23% increase for spirits − and progressively tightened drink–driving limits, raised the minimum drinking age, imposed night-time sales bans and enacted total advertising prohibitions. Importantly, these measures did not spur a surge in unrecorded alcohol use but instead bolstered public revenues and shifted social norms *(26, 27)*.

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