Alcohol availability and Gender Based Violence (GBV) in Southern Africa: **An evidence review**

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About the Southern African Alcohol Policy Alliance

The Southern African Alcohol Policy Alliance (SAAPA) is a collaboration of civil society organisations across Southern African countries, SAAPA is a network which aims to promotes the harmonisation and acceleration of evidence-based alcohol policy development and implementation in the region.

Southern African Alcohol Policy Alliance Approach

SAAPA subscribes to a health promotion and public health framework. Public policy, promoting community action, developing the skills of individuals, reorienting services and creating supportive environments are key principles for enabling sustainable change at individual and social level. Over the past decades research and interventions have focused on building the capacity of individuals and couples to address the GBV/IPV problem. As highlighted in the background of this document, alcohol is acknowledged as one of the key drivers of GBV. The intersecting nature of alcohol abuse and GBV as public health problems requires structural interventions in addition to individual and couple's intervention. SAAPA therefore is of the view that working towards evidence-based public policy and regulations informed by community 'realities' offers the opportunity to facilitate the development of environments that contribute to shifting social change i.e. alcohol trading practices and drinking norms to support individual behaviour change i.e. reduced perpetration and experience of violence.

ACRONYMS

AA	Alcoholics Anonymous
AOD	Alcohol Outlet density
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CETA	Common Elements Treatment Approach
CHC	Couples Health Co-Operative
DHS	Demographic Health Survey
DV	Domestic Violence
FF	Ford Foundation
GBV	Gender-based violence
HCT	HIV counselling and testing
HED	Heavy Episodic Drinking
HICs	High income countries
IPV	Intimate Partner Violence
IVPT	Integrated Violence Prevention Treatment
LMICs	Low- and middle-income countries
MHC	Men's Health Co-Operative
MI	Motivational interviewing
NCD	Non-communicable Disease
OTT	Outlet trading times
PBI	Parent-based intervention
PTSD	Post-traumatic stress disorder
RCT	Randomized control trial
SAAPA	Southern African Alcohol Policy Alliance
SADC	Southern African Development Community
SAMRC	South African Medical Research Council
SARR	Sexual assault and alcohol use risk reduction
SMART	Self-Management and Recovery Training
SSA	Sub-Saharan Africa
UN	United Nations
VATU	Violence Alcohol Treatment Zambia
VAWG	Violence against women and girls
WHC	Women's Health Co-Operative
WHO	World Health Organization

INTRODUCTION

Alcohol consumption is a key driver of intimate partner violence (IPV), the most prevalent form of gender-based violence (GBV) globally. One in three women (736 million) globally report having ever experienced intimate partner sexual and physical violence or non-partner sexual violence in their lifetime **(1)**. Simultaneously, alcohol is consumed by 2.3 billion people globally, with 50% of current drinkers doing so in a heavy episodic pattern (≥5 drinks: 60g) in single occasion in the past month **(2)**.

Regionally, the rates of GBV remain high, with 33% of women (aged 15-49 years) in Sub-Saharan Africa reporting having experienced intimate partner violence in their lifetime **(1)**. In terms of alcohol consumption in the African region, 32.2% of the population consume alcohol, and almost 40% of drinkers drink in a heavy episodic manner **(2)**. Furthermore in some Sub-Saharan African countries, heavy episodic drinking is as high as 60% among current drinkers **(2)**. Heavy episodic drinking, particularly binge drinking has been associated with both the frequency and severity of IPV **(3-5)**. This intersectionality has important consequences for public health. However, limited data in sub-Saharan Africa (SSA) on evidence-based interventions to address this intersection results in a response that is inadequate to the scale of the problem.

Drivers of GBV

A useful starting point to planning effective prevention programmes for GBV is understanding its drivers. The past 25 years of research has focused on (a.) identifying measurable and modifiable drivers of GBV, especially intimate partner violence (IPV) at multiple levels, and (b.) planning interventions to address them. Following an earlier ecological framework, Heise highlights that drivers of IPV exist at the individual, relationship, community, and societal levels **(1)**. This became the main approach to identifying and recognising drivers that impact on IPV exist at multiple levels, and in 2011 Heise updated this approach. She found that childhood violence, situational triggers (infidelity, money, distribution of household resources, division of labour and male drinking) and patriarchy were salient drivers of IPV **(2)**. A slightly different approach to understanding drivers of GBV has been by focusing on a range of latent constructs (those that cannot be directly measured, but which operate to impact on IPV). A key latent variable was masculinity and specifically 'male superiority' and the 'culture of violence' as key influencing factors of IPV, and how these operated with poverty as structural drivers of violence **(3)**. These structural factors operate both directly to drive GBV, but also through 'processes' such as increased alcohol use, poorer mental health, child abuse, to further increase GBV. The work on understanding and expanding the body of evidence on the drivers of IPV continued to gain momentum and a recent update of drivers, based on evidence from 15 global IPV prevention evaluations **(4)** and United National Multi-Country Study on Men and Violence in Asia and the Pacific **(5)** provides a comprehensive account of the currently recognized drivers of IPV. Rather than providing a list of different risk and protective factors at multiple levels, it sought to show how poverty and patriarchy, as well as conflict, are key structural drivers of GBV. These all increase childhood trauma, poor mental health and substance misuse, and poor communication and conflict in relationships, which in turn impact on IPV. Alcohol, which is located within this framework is widely recognised as one of key drivers of GBV, shaped by poverty and masculinity, but also childhood trauma, poor mental health, and conflict in relationships, often exacerbating these as well as being driven by these.

Globally, there has been a debate on the causal role of alcohol in GBV, due to concern that alcohol misuse is used as an "excuse" for perpetration of violence. However, the field has advanced in its understanding of this association and numerous studies globally and in low-to-middle-income countries (LMICs), where drinking alcohol is common, found that alcohol is a key driver of GBV **(6-8)**. Specifically, evidence found from SSA found that harmful alcohol use is inextricably linked to IPV. It illustrates this with results from studies in low-middle income settings showing that harmful

alcohol use by men increases women's risk of experiencing IPV; when alcohol use reduces, so too does IPV perpetration and experience thereof **(9)**, and that several modalities including gender transformative interventions, and couples psychotherapeutic interventions have potential to reduce alcohol-related GBV. This review's position, therefore, is that alcohol is one of several important currently recognized drivers of violence globally, and its regulation and control in relation to reducing GBV, particularly in Sub-Saharan Africa needs further interrogation.

This comprehensive evidence review broadly summarises what is known about the association between alcohol and GBV, and what is known about current interventions to address them globally. It also provides the landscape of the legislative and regulatory framework related to both alcohol and GBV in Botswana, Namibia, South Africa and Zimbabwe. It will centre the role of the WHO's criteria for alcohol availability and its association with harm i.e. alcohol density of liquor outlets (AOD) and outlet trading times (OTT), with a particular focus on evidence from these four Southern African countries. However, this focus is not to the exclusion of other evidence-based factors described above that exist at multiple levels of the socio-ecological environment, which directly or indirectly impact on GBV.

Methodology

This review provides an overview of the epidemiology of alcohol (mis)use, and of GBV (physical and/or sexual intimate partner violence (IPV) and non-partner sexual violence) in four sub-Saharan African countries, an overview of evidence-based drivers, including alcohol use as a key driver of GBV. It centres on one of the World Health organisation's (WHO) recommendations for structural interventions for reducing harmful alcohol use, viz **reducing alcohol availability** in four Sub-Saharan African countries. The review seeks to a) understand these structural interventions, effectiveness of alcohol availability restrictions i.e. AOD and outlet trading times on the reduction of alcohol use and abuse; b) the effectiveness of alcohol interventions on the reduction on women's experience or men's perpetration of GBV (physical and sexual IPV and non-partner sexual violence) in SSA. Although not a systematic review, the review follows the core principles of a systematic review in order to evaluate the current evidence base on strategies to prevent alcohol related GBV. To be included in the review, studies had to:

i) Be published in peer-reviewed literature or as international policy guidelines between January 1 2000 - December 31 2020, although some exceptions are noted below;
ii) Be an intervention that measured physical and/or sexual intimate partner violence (IPV) or, non-partner sexual violence (rape);
iii) Be a randomised controlled trial (RCT) or a quasi-experimental study, qualitative studies only were excluded;
iv) Be a systematic review of alcohol availability, and/or of alcohol availability and gender-based violence.

A search was conducted of Google Scholar, PubMed, and Google, as well as searching websites of bilateral and multilateral donors involved in alcohol and GBV work.

The burden of alcohol use and GBV in SSA

Alcohol use is a formidable public health problem in sub-Saharan Africa, where the prevalence of heavy episodic drinking is as high as 60% among drinkers in some countries **(2)**. In 2016, the harmful use of alcohol resulted in an estimated 3 million global deaths, with the African region experiencing the highest age-standardised alcohol–attributable burden of disease and injury **(2)**. Among both acute and chronic consequences, harmful use of alcohol has negative consequences for interpersonal violence, particularly GBV.

Despite many countries in the global South experiencing GBV and alcohol use as significant intersecting public health problems, there is curently limited evidence from SSA examining these associations, and consequently implications for prevention programming in these contexts. Of the studies that consider these associations, many attest to the

role of alcohol in GBV. Findings from the six country Asia-Pacific study on men's violence, found that harmful alcohol abuse was associated with lifetime perpetration of IPV in three of the settings, although it is worth noting that some of these settings (Bangladesh and Indonesia) are majority Muslim settings, and so had very low levels of alcohol consumption **(10)**. A recent study examining nationally representative DHS data from 86 024 women in 14 countries in Sub-Saharan Africa found that partner alcohol use was strongly associated with men's perpetration and women's experience of IPV in Sub-Saharan Africa **(11)**. In addition, an evidence review examining the association between harmful alcohol use, poor mental health and intimate partner violence in five low to middle income settings (4 from SSA) also found clear associations between alcohol use and men's perpetration and women's experience of IPV, alongside an increase in poor mental health outcomes for women, in particular **(9)**. Given the alcohol- GBV nexus, interventions aimed at reducing harmful alcohol use are likely to also have an impact on reductions in GBV.

Similarities between four SSA countries

Notwithstanding in-country diversity, there are some similarities between the four Sub-Saharan countries under review. For example, Table 1 indicates the similar prevalence of drinking across most of the countries, and a pattern of drinking in all countries characterised by heavy episodic drinking (HED), which is defined as the consumption of at least 60 g of pure alcohol during at least one occasion in the past 30 days **(2)**. Socio-politically, all countries have a history of having been colonised, either by the Dutch, British, or Germans, which has impacted not just on how they have been clustered together for administrative and reporting reasons, but also impacted on their socio-economic circumstances and drinking behaviour. For example, during the colonial era, "native" populations in many of the SSA countries were prohibited from drinking "European liquor" because it was perceived to make them disobedient and difficult to control **(12)**. In the 1900s, various new regulations were enacted to regulate drinking, primarily among native Africans, including the introduction of beer halls, and ultimately the proliferation of many illegal shebeens, as well as homebrews **(12)**. In terms of economic status, three of the countries (Botswana and South Africa and Namibia) are classified by the world Bank as upper middle-income countries, while Zimbabwe is classified as a lower-middle income country. In addition, all countries have a majority non-Muslim population, meaning that drinking is largely permitted and not religiously sanctioned. In terms of gender equality, all four countries subscribe to a dual system in which the constitution recognises the formal statutory system, and the informal or traditional systems pertaining to for example, marriage. Legislation in all countries have some policies in place to address both alcohol use and GBV, but they have either been characterised as being weak **(13)**, or where stronger policies exist, they have not been effectively enforced and/or subject to interference from the alcohol industry **(14-16)**. The socio-demographic, religious political and economic similarities of the four SSA countries are relevant to alcohol consumption and its impact on GBV and will be addressed in the relevant sections that follow in this review.

Table 1: Prevalence of current alcohol use and GBV in South Africa, Botswana, Namibia, and Zimbabwe

Country	*Alcohol Prevalence (%)	*Heavy Episodic drinking (%)	**GBV Prevalence (%)
South Africa	31	59	26
Botswana	32	59	***67
Namibia	30	60	33
Zimbabwe	18	51	35

* Source: WHO Global Status report on Alcohol and Health, 2018
** DHS in-country data
*** GBV Indicators

South Africa

South Africa, an upper middle-income country, with a total population of 58.56 million (2019) has an estimated 31% of current drinkers. When disaggregated by gender, 42% comprise male and 19% female drinkers **(2)**. Furthermore, the patterns by which South Africans consume alcohol is worrying. Among those who drink, 59% do so in a HED manner (≥5 drinks: 60g on a single occasion past 30 days) **(2)**, and males (70%) outnumber females (33%) in HED. National surveys attest to the harmful patterns of alcohol consumption, both among adult and adolescent populations **(17-19)**. GBV is a significant intersecting problem with harmful alcohol use in South Africa. At the first Presidential Summit on GBVF in November 2018, the President of the Republic declared GBV and femicide "a national crisis" **(20)** and in subsequent public addresses highlighted the role of alcohol in GBV. While the most recent population-based national Demographic Health Survey (DHS) in 2016 estimates that 26% of South African women experienced emotional, physical, or sexual violence by an intimate partner in the past year **(17)**, these figures are masked by variations in sub-groups, where rates of GBV, particularly IPV are much higher. For example, studies from informal settlements in South Africa (Ethekwini municipality) and (City of Johannesburg Municipality) found rates of lifetime physical and sexual IPV to be as high as 65% and 60% respectively **(21, 22)**.

As in the rest of the world, harmful alcohol and GBV are inextricably linked in South Africa, although the literature base on this association remains limited. Of the limited available studies, there is clear evidence that men's alcohol use overlaps with the perpetration of IPV, as well as other sexual risk behaviours **(23)**. Results from the South African Stepping Stones and Creating Futures intervention, and its predecessor, Stepping Stones also found clear associations between IPV and alcohol use **(21, 24)**. Other research has found that alcohol use is also associated with non-partner sexual violence (particularly rape) in South Africa **(25)**. Although data on rape is less available for most SSA countries, largely due to non-reporting, available studies from South Africa show that men who perpetrate rape often consume more alcohol than those who do not **(26)**.

Botswana

Botswana, a small landlocked country in Southern Africa, with an estimated population 2.304 million (2019), borders South Africa, Namibia, and Zimbabwe and has an estimated 32% of current drinkers and 59% of heavy episodic drinkers. In keeping with global trends, males outnumber females both in overall drinking, as well as HED in the country. Among drinkers, 71% of men and 35% of women reported HED in 2016 **(2)**. There has been no nationally representative data on the prevalence of alcohol use in Botswana. This limits the ability to make evidence-based decisions on both preventing and responding to alcohol use in the country. However, evidence from the nationally representative 2012 GBV indicators survey found that 60% of men and 32% of women consumed alcohol in the past 12 months **(27)**. Furthermore, both the WHO global status report, and cross-sectional in-country research indicates that problematic alcohol use is prevalent in Botswana.

Gender Based Violence (GBV) is also a significant public health problem in Botswana. In the absence of a recent DHS, the GBV Indicators research project conducted in 2012 remains the most recent comprehensive national level assessment of the prevalence, consequences, and responses to GBV in Botswana **(27)**. It found that 67% of women report having experienced some form of GBV in their lifetime, and 44% of men report perpetrating violence. One in three women (29%) report having experienced IPV in the past 12 months , while 22% of men admitted to perpetrating the IPV in the same period. In addition, 11.4% women and 10.7% of men reported experiencing and perpetrating non-partner rape in their lifetime respectively.

In terms of alcohol, almost a quarter of men (24%) who perpetrated IPV in the past 12 months, report consuming alcohol in the same recall period. Of the men who consumed alcohol in the 12 months prior to the survey, 19%

perpetrated IPV, while 4% did not. Among this group of men, 14% perpetrated emotional IPV, while 3% did not and 5% perpetrated sexual IPV, while less than 1% did not in the same period **(27)**. Qualitative research in Francistown, Botswana on the role of alcohol in domestic violence found that alcohol use and, particularly excessive alcohol use was associated with psychological, physical and economic abuse **(28)**. Specifically, key informants reported that in more than half the cases of reported GBV cases, the perpetrator was under the influence of alcohol.

"In more than 50% of the (GBV) cases reported here we learnt from a number of witnesses other than victims that the abusers were not violent when they were sober but became violent when they were intoxicated"

(District commissioner) (28)

Namibia

Namibia, is a small upper-middle income sub-Saharan country in southwest Africa, with an approximate population of 2.495 million people (2019). According to the most recent WHO global status report on alcohol and health, 30% of Namibians are current drinkers. Similar to its SSA counterparts, the drinking profile in Namibia is characterised by HED, with 60% of drinkers doing so in a heavy episodic pattern, and male drinkers (72%) outnumbering female drinkers (36%) in the prevalence of HED **(2)**. Namibia consistently features as a country with not just a high prevalence of alcohol use, but also of alcohol use disorders and alcohol dependence **(2, 29)**.

Nationally, results from the most recent Namibian DHS found that one in two women (50%) and three in five men (57%) reported drinking alcohol in their lifetime. In keeping with global patterns of drinking men (31%) had higher rates of engaging in HED than women (23%) **(30, 31)**. The issue of GBV is described as "an endemic problem" in Namibia, with over a third (33%) of ever-married women age 15-49 having reported experiencing physical, sexual, and/or emotional violence from their spouse in their lifetime, and 28% having reported experiencing this in the past 12 months **(30)**. Findings from a Ministerially commissioned national survey in Namibia, the Social Impact Assessment and Policy Analysis Corporation study, found that (34.6%) of female respondents and 16.4% of male respondents reported being hit or slapped by their partners, while a WHO study found that 36% of women in a long-term relationship had experienced physical or sexual violence in their lifetime **(32)**. The most widely recognised drivers of GBV in Namibia include cultural acceptance of violence perpetuated against women and patriarchal norms **(33, 34)**. Despite the high prevalence of alcohol use and dependence in Namibia, its association with GBV has not been fully explored. The evidence for this association comes largely from exploratory or qualitative studies, and technical reports, all of which attests to the positive association between alcohol use and GBV **(33, 34)**. Qualitative research undertaken in Namibia found that there is a proliferation of alcohol outlets in both rural and urban Namibia; alcohol functions as a risk factor for sexual risk behaviour, particularly exchange of alcohol for sex among young girls; underage drinking is prevalent; and alcohol is easily available **(35)**. In addition, qualitative research examining the association between alcohol and GBV in Namibia found that heavy alcohol use, in particular, is associated with physical and psychological violence perpetration by men, with alcohol use being a trigger for violence perpetration. Among some women who experience GBV, alcohol is reported to be used as a coping mechanism after GBV has occurred **(33)**. Accounts from wives of heavy drinking husband reported that the "presence of shebeens" resulted in heavy drinking, and that heavy drinking resulted in a change in their husbands behaviour, exacerbated by environmental stressors such as unemployment **(33)**.

"My husband drinks but I don't drink but the things he says when he is drunk disturb me. He also says I go to other men just because he is unemployed, and that they buy me things that I need simply because he can't provide"

(Anna) (33)

"My partner drinks on a daily basis; just look around you what can you expect? Beer is everywhere, look at these shebeens, it is even sold at some homes illegally. For me, my worst experience is one time he went away for days and he came back very drunk he demanded to sleep with me. So, when I refused he just physically beat me."

(Rosia) (33)

Zimbabwe

Zimbabwe is a low-income landlocked country with an estimated population of 14.65 million people (2019). Despite only 18% of the population being current drinkers, 51% drink in a HED manner. When disaggregated by gender, males (61%) outnumber females **(26)** in HED. While the most recent DHS conducted in Zimbabwe does not provide an estimate of alcohol consumption, it does estimate that among women who reported that their husbands were frequently drunk, 75% experienced physical, sexual, or emotional spousal violence **(36)**. Gender based violence is prevalent in Zimbabwe; one third of ever-married women (35%) report having experienced physical or sexual violence from a spouse since age 15, of these 37% report experiencing physical injuries as result, and 15% report experiencing physical violence from a spouse in the past 12 months. Thirty two percent of women report having experienced emotional violence from a partner in their lifetime, and 24% of these report experiencing the same in the past 12 months **(36)**. Trend data from DHS on IPV in Zimbabwe found that between 2005-2015 the prevalence of IPV decreased from 45% in 2005 to 40% in 2010, but increased again to 43% in 2015 **(37)**. Both early and more recent research on GBV in Zimbabwe found that the lack of women's economic empowerment, women's low status in the family, stress related to rapid social and political change, gender inequitable social norms, alcohol use and the normalization of violence are some of the key drivers of GBV in Zimbabwe **(36, 38, 39)**. Again, despite the burden of both alcohol and GBV, and evidence of their inter-relatedness from available research, much of the research from Zimbabwe is limited to studies among small cross-sectional samples. Qualitative data from Zimbabwe on stakeholders perspectives on the causes of GBV highlighted alcohol as a key driver of GBV, with some stakeholders reporting that "beer holes", bars and shebeens characterised as risky places where drinking, violence and sex work took place **(38)**.

THE REGULATORY AND LEGISLATIVE CONTEXT OF ALCOHOL AND GBV IN SOUTH AFRICA, BOTSWANA, NAMIBIA, AND ZIMBABWE

Many countries in SSA subscribe to a range of global, regional and national policy frameworks to prevent and respond to both harmful alcohol use and GBV in their respective contexts. (See Table 2). While these remain too many to name here (See Appendix A), it is notable that the four countries under review have various international and national level policies and interventions in place to address alcohol and GBV. However, several challenges impede meaningful and effective prevention and response.

South Africa

South Africa is considered to have a very progressive legal and policy framework for addressing gender equality. It scores 19 out of 149 countries on the Global Gender Gap score **(40)**. In addition to being a signatory of international treaties (CEDAW, Maputo Protocol and the Beijing Declaration), it is actively involved in national policy reform to address gender-based violence, with the ultimate goal being gender equality. These include the Domestic Violence Act (1998), Presidential Emergency Response Action Plan 2020 (ERAP) to address (GBVF) and the National Strategic Plan on Gender-based Violence and Femicide 2020 (NSP-GBVF) **(41)**.

In terms of alcohol policy, significant strides have been made in alcohol policy development in South Africa in the past three decades. South Africa subscribes to international (WHO 2010 Global Strategy to Reduce the Harmful Use of Alcohol, Global action plan for the prevention of NCD 2013-2020: Best buys), regional (WHO regional strategy for the reduction of harmful alcohol use, 2010).

Alcohol policy is formulated at national level and translated into national and provincial legislation, and municipal by-laws. However, these are not applied in a harmonised manner, often leading to uneven regulations across the country. For example, the national Norms and Standards of 2016 sets out the regulation of days of sale. Its implementation differs by province in South Africa, where the licensing of the sale of liquor falls under the remit of individual provinces and sometimes differs even within provinces. In practice, this means that liquor can be sold on a Sunday in one province but not in another province. Should a municipal by-law prohibit the sale on a Sunday, one may be able to purchase alcohol in one municipality but not in another within the same province. In terms of alcohol outlet density (AOD) no limits have been set in South Africa, though these are currently being considered. The National Liquor Amendment Bill (2017) sets out criteria for reducing availability by limiting trading hours and days, introducing trading zones, and restricting the location of alcohol outlets. It includes other regulations e.g. increasing the legal drinking age to 21 years, limiting alcohol advertising, and liability for alcohol distributors, retailers, and traders whose patrons may be held responsible for alcohol-related harm. However, the adoption of the Bill has been stalled. (See case study 1). At a provincial level, the 2003 Gauteng Liquor Act sets proximity criteria for alcohol outlet density by stipulating that it would only grant licences for alcohol premises not situated within a 500m radius of a place of worship, educational institution, similar licenced premises, or public transport facility **(42)**. However, this is not effectively implemented to date, and remains a good policy approach "on paper" only.

A similar scenario has played out with regards to outlet trading times. The National Liquor Act Norms and Standards recommends that the trading times in all provinces should be aligned with the minimum standards of trading hours **(43)**. However, to date this remains differentially implemented, with provinces trading at different times and lengths of time **(44)**.

In summary, despite the presence of national policy in South Africa, these are either not uniformly applied or efforts are thwarted by poor enforcement. This is due in large part to the lack of translation into national and provincial legislation, resulting in uneven implementation of regulations across the country. In addition, the South African government have not acted upon calls to reignite the process of liquor amendment bill to date (See case study 1).

CASE STUDY 1

SOUTH AFRICA, DELAY IN ADOPTION OF LIQUOR AMENDMENT BILL OF 2017

In response to the World Health Organisation's (WHO) call to reduce the harmful use of alcohol, the South Africa government, through the Department of Trade and Industry (DTI) signalled their political will and commitment to a reduction in alcohol related harms by adopting a new Liquor Policy in 2016. The policy stipulates:

- licensing requirements such that the location of outlets not be within 500m radius from educational institutions, places of worship, recreational facilities, rehabilitation or treatment centres, residential areas, and public institutions;
- reducing availability by limiting trading hours and days, and introducing trading zones;
- increasing the legal drinking age to 21 years to curb binge drinking among young people, a particular high-risk group in South Africa;
- liability for alcohol distributors, retailers, and traders responsible for alcohol-related harm perpetrated by their customers; and
- limiting alcohol advertising, including a complete ban of alcohol advertisements on social media, platforms largely targeting and used by young people.

The Liquor Amendment Bill based on that policy was approved by Cabinet in 2016 after extensive public participation, and two regulatory impact assessments. The adoption of the Bill would create a shift in the alcohol retail and marketing environment. However, since 2017, following pressure from the alcohol industry, the adoption of the Bill has been delayed, and in effect put into abeyance.

Botswana

Botswana lags behind its counterparts in terms of gender equality, scoring 55 out of 149 countries on the Global Gender Gap score **(40)**. In 2008, the country passed the Domestic Violence Act (DVA) to protect survivors from domestic abuse, which it defines as "any controlling or abusive behaviour that harms the health or safety of the applicant" **(45)** and defines the types of abuse as physical, sexual or emotional, abuse. However, it does not make provisions for women outside of a marriage (cohabiting) or for sexual abuse within a marriage. Hence, the DVA was criticised by the UN's Committee on the Elimination of Discrimination Against Women for having a dual system and customary laws that discriminates against women **(46)**. Botswana developed the National GBV Strategy 2016-2020, a multi-sectoral approach to preventing and responding to GBV **(47)**. Alcohol is only mentioned once as a strong enabler of gender-based violence in the strategy, but nothing further is mentioned regarding how to address alcohol-related GBV. In terms of alcohol policy, Botswana has a long and complicated relationship with alcohol control policy. Despite several attempts by the early traditional leaders to ban alcohol in the 1800's, alcohol use continued as an "underground activity" **(16)** thwarting such legislative steps to ban alcohol. Since its independence in 1966, several strides have been made in alcohol policy development, including the recognition of alcohol use as a major public health and social problem, the promulgation of the Trade and Liquor Act of 1986, later revised into the Trade Act, 2003 (Act No. 5 of 2004) and the Liquor Act, 2003, and a proposal in 2008 by the Botswana Presidency for a 70% levy on alcohol products, later reduced to 30% **(16)**. Currently Botswana has a written national alcohol policy (2011) and restrictions on **availability** of alcohol (hours, days of sale) , but not on alcohol outlet density. In 2014 the Ministry of Health amended the liquor trading hours/days by outlet type. For example, the hours of sale at a bar, liquor depot, and club liquor were reduced from 9am-11pm Monday to Thurs to 2pm-10pm on the same days. The sale of liquor on Sundays and public holidays was reduced from 11am-11pm to 3pm-10pm. This however changed in 2018, following pressure from the alcohol industry, resistance from

drinkers and traders to the policy, and the change in Presidential administration. While there were progressive steps in alcohol control, pressure from the alcohol industry, the proliferation of un-regulated informal alcohol outlets (shebeens) which trade in opaque liquor (e.g. sorghum/traditional beer), and poor implementation of the existing policy threaten to reverse the gains of alcohol policy development in Botswana (See case study 2).

CASE STUDY 2

THE BOTSWANA ALCOHOL POLICY AND THE LEVY

The Botswana alcohol levy is a case of an effective tax policy that was not fully implemented due to a lack of extensive consultation with stakeholders, heavy interference from the alcohol industry, including threatened legal action, and biased portrayal by the media, heavily influenced by the alcohol industry **(16)** of only the negative effects (e.g. job losses) of the levy. The alcohol levy was shrouded in controversy when it was first proposed in 2008 as a 70% levy on alcohol products, later reduced to a 30% tax. However, the alcohol industry argued that even a 30% levy would not address the issue of harmful drinking and approached the high court with an urgent application to stop the Botswana government from implementing the 30% levy. It demanded a review of its application, as well as further deliberations between government and the industry.

However, on 31 October 2008, Botswana President Ian Khama released the levy on Alcohol Beverages Fund Order,2008 **(16)**. In addition to the release of the Alcohol Beverages Fund order, 2008, the hours of trading times were reduced, and the sale of alcohol from homes became illegal **(48)**. For example, the hours of sale at a bar, liquor depot, club liquor were reduced from 9am-11pm Monday to Thurs to 2pm-10pm on the same days. The sale of liquor on Sundays and public holidays was reduced from 11am-11pm to 3pm-10pm. In 2010, the alcohol levy was increased to 40%, further increased to 50% in 2013 and for beverages exceeding 5% volume, to 55% in 2015. However, this changed again in 2018 to 35%, following pressure from the alcohol industry, resistance from drinkers and traders to the policy, and the change in Presidential administration. Since 2018, the effects of the levy on job, profit and personal income losses have been fore fronted in the media while the benefits of the levy, including lower drinking rates, less spend on alcohol and its related risks, and lower vehicle accidents have been neglected **(13)**. To date alcohol industry continues lobbying the government to further reduce alcohol levy.

Namibia

The policy environment for gender equality in Namibia is considered to be very progressive, particularly since it achieved its independence from South Africa in 1990. On the Global Gender Gap report 2018, Namibia scores 10 out of 149, the highest among the four countries under review **(40)**. Namibia subscribes to a range of policies and declarations via the United Nations (UN), the African Union (AU) and the Southern African Development Community (SADC) **(49)**. In recognition of two separate judicial systems at independence: the formal statutory system based on Roman Dutch law and an informal, or traditional, system, Namibia subscribes to a dual system to address GBV. Both systems operate alongside each other, although neither may violate the constitution as the supreme law of the land.

In spite of its heavy alcohol burden, Namibia has no written national policy or action plan on alcohol use, according to the WHO. The Namibian Liquor Act, No 6 of 1998 is the alcohol legislation, that regulates the sale and supply of liquor, the licencing and zoning of liquor outlets and control of certain alcoholic substances and prohibitions **(50)**. However, it is often criticised as being outdated and weak. It does however have some restrictions on **availability** of alcohol (hours, days / places), but not on alcohol outlet density, which is a prevalent problem in Namibia. Several studies conducted in Namibia attest to the proliferation of alcohol outlets in both urban and rural areas and the term "mushrooming of alcohol outlets" is often used to describe the growth of alcohol establishments in Namibia. These outlets are usually formal and informal premises that are used for the sale of on and off premise consumption of liquor and refreshments. This is partly due to an increase in shebeens in the post-independence era in Namibia, the avoidance of the costs and efforts associated with obtaining a licence, as well as efforts to ensure that basic economic needs are met through the sale of alcohol. A popular example of an area with a high concentration of shebeens is that of Eveline Street in the Greenwell Matongo in Windhoek, though the existence of shebeens extends

well into many rural communities in Namibia too. Eveline Street, a residential area, that has been transforming into an entertainment hub, and has been popularised for its bars, shops and restaurants, but has also been referred to as resembling "Sodom and Gomorrah', given its large number of illegal shebeens and reported criminal activity and social problems **(51, 52)**. In terms of hours of trading, the Namibian Liquor Act, No 6 of 1998 stipulates that alcohol may be sold only during business hours and the sale of alcohol is prohibited on Sundays. However existing evidence suggests that these hours are largely contravened, with shebeens operating as long as 15 hours a day **(52, 53)**. In addition to resistance from shebeen owners, efforts to regulate alcohol sale and consumption in Namibia are also subject to influence from the alcohol industry **(53)**. Not unlike other SSA countries, the alcohol control regulations in Namibia are in place, but its effectiveness is thwarted by contraventions, poor enforcement, and industry involvement in alcohol policy.

Zimbabwe

Zimbabwe's policy progress on Gender equality can be measured by its ranking in the Global Gender Gap report 2018, where it scores 47 out of 149 in the Global Gender Gap score **(40)**. However, the constitution of Zimbabwe (2013) does provide a solid legal framework to promote gender equality **(54)**, in addition to the Domestic Violence Act which was passed in Zimbabwe in 2006 **(55)**. In terms of alcohol policy, the early Liquor Act (1984-Chapter 14:12) governed the licencing, control of the sale and supply of liquor, and the conduct of licenced premises **(56)**. In addition, other legalisation applying to all alcoholic beverages which are sold or manufactured for sale in Zimbabwe include the Traditional Beer Act of 1984 Chapter 14:24 **(57)** and the Food and Food Standards (Alcoholic Beverages) Regulations 2001 **(58)**. In 2010 Zimbabwe released a revised national alcohol policy **(57)**. However, adoption of the policy has been delayed, largely due to opposition from the alcohol industry, making it difficult to implement. This draft policy is heavily influenced by the alcohol industry, and perusal of it indicates that it had limited CSO participation and despite, referring to outlet trading times, it is silent on the detail of what these strategies will entail and on how it will be implemented **(57)**.

Table 2: National level Alcohol and GBV Legislation and Policies in South Africa, Botswana, Namibia, and Zimbabwe

South Africa		Botswana		Namibia		Zimbabwe	
Alcohol	**GBV**	**Alcohol**	**GBV**	**Alcohol**	**GBV**	**Alcohol**	**GBV**
Liquor Act, 59 of 2003	Constitution of the Republic of South Africa 108 of 1996	Trade and Liquor Act of 1986	Domestic Violence Act in 2008	Liquor Act 6 of 1998	The Combating of Domestic Violence Act 4 of 2003	Traditional Beer Act 14:24	Domestic Violence Act 2006
Gauteng Liquor Act, 2003**	The Bill of Rights under the Constitution	Trade Act, 2003 (Act No. 5 of 2004)	National GBV Strategy 2015-2020		The Combating of the Rape Act 8 of 2000,	Liquor Act (Chapter 14:12)	
W Cape Liquor Bill of 2005**	Domestic Violence Act of 118 of 1998	Levy on Alcohol Beverages Fund Order, 2008			The Protocol of the African Charter on Human and People's Rights of Women in Africa and the SADC Protocol on Gender Development	Food Standards (Alcoholic Beverages) Regulations 2001	
Norms and Standards in Terms of the Liquor Act, 59 of 2003 (2015)	Sexual Offences Act 32 of 1957	National Alcohol Policy, 2010					
National Liquor Norms and Standards, 2014	Criminal Law Amendment Act (2019)	Traditional Beer Regulation, 2011					
The Liquor Amendment Bill 2016 (stalled)	National Strategic Plan on Gender Based Violence and Femicide 2020						
	Domestic Violence Amendment Bill 2020						
	Criminal justice reform bill 2020						

ALCOHOL INTERVENTIONS IN SSA

Many interventions exist at multiple levels to reduce alcohol use, but less is known about how these interventions impact on reducing the experience of violence among women and the perpetration of violence among men. These identified alcohol interventions include:

- **Alcohol screening and brief interventions:** These interventions are usually of short duration and used to identify and intervene with problem drinkers, or as a complement to universal and/or tailored prevention approaches.
- **Community-based interventions:** These interventions are aimed at modifying the drinking environment through social norms campaigns, often through education in schools or public dialogues.
- **Treatment and self-help support systems:** These interventions include therapeutic approaches to intervene by raising awareness of a person/group's awareness of positive and negative thoughts and behaviour with the aim of effective problem solving. Other self-help systems include Alcoholics Anonymous (AA), SMART (Self-Management and Recovery Training) Recovery, Women for sobriety, and Al-Anon.
- **Structural interventions:** These interventions include alcohol taxation, policy and pricing, regulating density of outlets and operating hours, and the distribution and retail of alcohol, and the costing of alcohol and its related harms **(59-62)**.

Structural interventions

The focus of this review is on structural interventions, in particular on reducing the **availability of alcohol** by restricting alcohol outlet densities (AOD) and outlet trading times (OTT). Structural interventions are designed to make alcohol less available and affordable to the general public. They are recommended by the WHO, as among the "best buys" to reduce the harmful use of alcohol globally, meaning it is considered both cost-effective and feasible to implement at a population level **(63)**. The "best buys" continue to be underpinned by strong economic costing data, which also recommend reducing the availability of alcohol (reduced hours of sale) and restricting advertising as key cost-effective legislative actions to reduce alcohol-related harm **(64)**. Although structural interventions have been in place globally for a long time, the extent to which they are implemented, particularly in SSA has been varied, inconsistent and challenging. Yet, an example of the positive effects of structural interventions (availability and outlet trading times) on reductions in alcohol and alcohol-related harm can be been seen through the "natural experiment" that occurred during the COVID-19 related lockdown in South Africa. Results from a preliminary study which observed trauma admissions during the pre-COVID (1 February-March 2020) and COVID period, during which the sale of alcohol was banned (May-June 2020), found that a ban on alcohol sales coincided with a decrease in the mean of 53% of trauma admissions, a 15% decrease in admissions for gunshot wounds and an 85% decrease in drunk driving convictions. In contrast, in the period post lockdown, when the alcohol sales ban was lifted, there was an 80% increase in trauma admissions **(62)**. In addition, evidence from another South African study on the effect of the sales ban on "short-run mortality" found that the ban on alcohol and hard lockdown decreased the number of unnatural deaths by 21 per day, or approximately 740 over a five-week period **(65)**. Despite the justifiable concern that some of the reductions in both trauma admissions and decreases in unnatural deaths may be due to restrictions in movement, also mandated by the COVID-19 response plan in South Africa, the robust statistical analysis which accounts for this and other external variables, indicates that prohibition and/or the partial sale of alcohol during national emergencies still had a large and meaningful effect on some trauma admissions and injury-related mortality **(65)**.

This review draws out interventions that seek to address alcohol and GBV as intersecting problems. Table 3 shows 17 identified studies that **considered restricting alcohol availability as a means of reducing alcohol use, and abuse.** Table 4 shows interventions that **considered alcohol as a pathway to reducing GBV**. It found 13 interventions, 6 in SSA. In total we identified 30 studies, of which only 6 were conducted in SSA.

The rationale for including interventions which address alcohol as a pathway to reducing GBV is based on consistent evidence that alcohol use by one or both partners increases the risk of intimate partner violence perpetration and experience. It follows that intervening to reduce alcohol consumption, in part through reducing availability (AOD and OTT) will lead to a reduction in alcohol related GBV.

Table 3: Studies addressing reducing alcohol availability and alcohol use

17 STUDIES ADDRESSING ALCOHOL AVAILABILITY AND ALCOHOL USE

13 SYSTEMATIC REVIEWS

A systematic review examining the effectiveness of limiting alcohol outlet density on reducing excess alcohol use and alcohol-related harm **(66)**; a systematic review to prevent underage drinking and its health impact **(67)**; a systematic review examining the impact of hours and days of alcohol sale, and alcohol outlet density on alcohol consumption and alcohol-related damage **(68)**; a systematic review of the effectiveness of policies restricting hours of alcohol sales in preventing excessive alcohol consumption and related harms **(69)**; a systematic review of effectiveness of policies maintaining or restricting days of alcohol sales on excessive alcohol consumption and related harms **(70)**; a systematic literature review of the prevention of alcohol misuse among children, youths and young adults **(71)**; a systematic review of harm reduction in drinking environments **(72)**; a systematic review of the effects of alcohol retail privatization on excessive alcohol consumption and related harms **(73)**; a systematic review of community level availability and marketing of alcohol on alcohol use **(74)**; a systematic review of road safety measures and their effects on traffic injuries **(75)**; a systematic review of the impacts of changes to trading hours on alcohol-related harm **(76)**; a systematic review of the impact of policies regulating alcohol trading hours and days on specific alcohol-related harms **(77)**; a systematic review of the effects of extensions and restrictions in alcohol trading hours on incidence of assault and unintentional injury **(78).**

4 NON- RCT/ QUASI-EXPERIMENTAL STUDIES

- **1** observational study on alcohol outlet density and its relation to violence in Sao Paulo (2002) **(79)**;
- **1** report on the effect of restricting opening hours on alcohol-related violence in Sao Paulo (2007) **(80)**;
- **1** systematic community mapping and participatory group of AOD and alcohol marketing on alcohol consumption among young people (2019) **(81)**;
- **1** umbrella review and quality assessment of alcohol control interventions (2019) **(82).**

17 STUDIES IN TOTAL

- **13** systematic reviews of interventions examining alcohol outlet density, hours of trading times, (comprising 0 RCT's, 67 quasi-experimental studies, all with control arms)
- **4** evidence/umbrella reviews examining alcohol outlet density, hours of trading times, and/or underage drinking, and alcohol control interventions

OVERALL FINDINGS

Good evidence: There is good evidence from systematic reviews of the effectiveness of interventions that reduce alcohol availability to reduce both alcohol consumption and alcohol-related harm.

Effectiveness of the interventions:

Overall, there is good evidence from our review of the 13 systematic reviews, based on 67 quasi-experimental studies (all with control arms) of the effectiveness of interventions to **reduce alcohol availability** (reduced alcohol outlet density and outlet trading times) and a **reduction in both alcohol consumption and alcohol-related harm.** In addition, evidence from four non- RCT/ quasi-experimental studies (included as exceptions to the eligibility criteria) found that increased alcohol availability is associated with an increase in alcohol use. One umbrella review found that restricting both on and off-premise outlet density may be potentially beneficial for reducing alcohol use and its related harms. Overall, evidence is limited for interventions employing RCT designs to assess whether reducing alcohol availability by restricting alcohol outlet densities (AOD) and outlet trading times (OTT), reduced alcohol consumption and its related harms.

Evidence from systematic reviews

The evidence from the 13 available systematic reviews largely found that reducing alcohol availability by restricting alcohol outlet densities (AOD) and outlet trading times (OTT) was associated with reduced alcohol consumption and its related harms. The reviews are summarised below.

In one systematic review, Campbell and colleagues (2009) examined the **effectiveness of limiting alcohol outlet density on reducing excess alcohol use and alcohol-related harm**. The review referenced 10 primary studies, employing interrupted time series designs, and the quality of the evidence was categorised based on threats to validity of the findings (e.g. poor measurement of exposure or outcome, lack of control of potential confounders). Based on the threats to validity measures, they categorised studies as good (one or fewer threats to validity), fair (two-four threats) or poor (five or more threats). Only studies with good or fair evidence and suitable designs were included in the review. Based on these studies, they found that greater alcohol outlet density was associated with increased alcohol consumption and alcohol-related harms, including injury, crime and violence **(66)**.

A systematic review by Spoth and colleagues (2009) examined the evidence base on **interventions to prevent address underage drinking**. The review was based on 127 studies focusing on interventions targeting 3 developmental age groups (<10, 10–15, and 16 to ≥20 years of age). Of these, only 10 studies examined the effectiveness of alcohol availability (outlet density and hours of trading times) on underage drinking. The quality of all the studies was based on 6 criteria i.e. interventions 1.) had to have had an experimental design, (randomized trial design or a quasi-experimental design) with a comparison group, 2.) have a sample for which outcome was measured, had to be specified, 3.) have pre-intervention, post-intervention, and follow-up findings included, 4.) there had to have been a measurable difference in alcohol or alcohol-related outcomes, 5.) studies had to have met 7 quality of evidence criteria, and 6.) there had to have been a written manual with details of the target population and intervention procedures. For studies examining the effect of alcohol availability on underage drinking, they found positive effects of one community-based intervention **Mobilizing for Change on Alcohol effects** among high school or older Participants (16 to ≥20 Years of Age) on alcohol or alcohol-related harm. Specifically, 3 years post baseline, they found reductions in sales to minors, increased identification checks by vendors; reduced availability from non-commercial outlets; reduced community acceptance of underage purchase **(83)**. Overall, the risk of bias from the review was high, and results should therefore be interpreted with caution.

Another systematic review by Popova and colleagues examined **the impact of hours and days of alcohol sale, and alcohol outlet density on alcohol consumption and alcohol-related damage (68)**. The review was based on 44 studies on alcohol outlet density and 15 studies on hours and days of sale. Only studies that assessed the impact of an intervention or dependent variable and those that had sufficient information on the key variables, such as density

of outlets or hours or days of sale were included. The review found that the majority of the studies on alcohol outlet density and hours sale impacted one or more of the main outcomes, i.e. overall alcohol consumption, drinking patterns and alcohol-related damage. Specifically, they found that higher alcohol outlet density was associated with increased alcohol consumption (quantity, frequency). They found some variation in findings with regard to drinking patterns, with some studies showing that AOD was not associated with increases in drinking patterns and others showing an increase; and in general, studies showing that an increase in AOD was associated with increased alcohol-related damage, harm and problems (e.g. alcohol-related pedestrian collisions, and self-reported injuries).

Hahn and colleagues (2010) examined the **effectiveness of policies restricting hours of alcohol sales** in a systematic review, based on 10 studies **(69)**. In keeping with the Campbell review above, the quality of the evidence was categorised based on threats to validity of the findings, and those found to have one or few threats to validity were deemed good, those with two-four threats were deemed fair and those with five or more threats were deemed poor. Only studies with good or fair evidence were included in the review. Overall, the review found that increasing the hours of alcohol sales by 2 or more hours increased alcohol-related harms, and recommended that reducing alcohol sales by 2 or more hours is likely to prevent alcohol related harms at on-premise outlets. However, evidence from six studies was inconclusive in determining whether increasing alcohol sales by less than 2 hours increases alcohol misuse and alcohol-related harm.

Another systematic review by Middleton and colleagues **examined the effectiveness of policies maintaining or restricting days of alcohol sales on excessive drinking and related harms (70**).The review examined 14 studies , of which 11 assessed the effect of adding days of sale of alcohol, and 3 assessed the effect of banning alcohol sales on a given day in a weekend. The review included primary studies that evaluated long-term policy changes related to days of sale; the impact of changes in days of sale alone on excessive alcohol consumption or related harm, and that had a comparison group, or compared outcomes of interest before and after policy change. They found that increasing days of sales led to increases in excessive alcohol consumption and alcohol related harm. In contrast, decreasing the number of days of alcohol sales generally decreased alcohol-related harms. They recommended that restricting days of alcohol sales is an effective strategy to prevent alcohol-consumption and its related harms.

Korczak and colleagues conducted a systematic review on the **prevention of alcohol misuse, specifically among children, youth and young adults (71)**. The review was based on 59 studies and reports the findings in terms of socio-medical results and health-economic results. In terms of quality of studies reviewed, despite the overall high quality of the studies included, a number of studies had methodological limitations, e.g. missing randomisation. Nonetheless, findings from the socio-medical results indicate that multi-component programmes that include structural prevention, such as increasing alcohol taxes and prices, traffic control, restricting the proximal access to outlets and the days and hours of sale, control of the sales staff, limiting the advertising are generally effective in preventing alcohol misuse among young people.

In a systematic review by Jones and colleagues, they examined **reducing harm in drinking environments (bars)** by reviewing effective approaches from 39 studies to reduce alcohol use and its related harms. The quality of the studies included in the review were assessed based on the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool for Quantitative Studies **(84)** and the methodological quality of studies was based on an interrupted time series (ITS) design, Cochrane Effective Practice and Organisation of Care group **(85)**. The review prioritised studies that were categorised as strong and moderate, and those that were weak, need to be interpreted with caution. Overall, they found that multi-component programmes including; community mobilisation, responsible beverage service training, control on alcohol outlet density, components of drinking driving measures and measures to curb underage drinking reduced the quantities of alcohol consumed, alcohol-related traffic accidents and assault **(72)**. The review points to two projects as promising multi-component programs , the **Community Trials project**, a 5 year multi-component project which found significant reductions in the quantities of alcohol consumed and alcohol related harms in the intervention communities **(86)**. It also highlights the **STAD project**, a 10 year multi-component

community action program, which combined community mobilisation, responsible beverage server training, and stricter enforcement of existing alcohol laws, and found significant reductions in violent crimes (assaults, illegal threats and harassment, violence and threats targeted at door staff/police) in the intervention communities **(87)**.

A 2012 systematic review by Hahn and colleagues examined the **effects of privatisation of alcohol retail sales on excessive alcohol use and related harms** based on 17 studies **(73)**. The quality of studies included in the review was based on design and execution. Prospective studies with exposed and comparison groups were categorised as the highest quality, while studies with moderate designs suitability were retrospective studies with exposed and comparison groups, or in which there were multiple pre- or post-intervention measurements, but no concurrent comparison population. Cross-sectional studies or those in which there was no comparison population were considered to be of least quality. Only studies with high and moderate quality were included in the review and are reported. The study followed the conceptual argument that the privatisation of alcohol retail sales generally led to an increased density of off-premise alcohol outlets **(66)**, and increased availability by increasing the days and hours of alcohol sales. They also contend that in contrast government-controlled outlets result in lower outlet density. Following these conceptual hypotheses, they concluded that privatisation of alcohol retail sales (and by implication an increase in outlet density) led to an increase in alcohol consumption.

Bryden and colleagues conducted a systematic review of **the effect of community level availability and marketing of alcohol on alcohol use** in 2012 **(74)**. The review was based on 21 studies on the influence of alcohol availability on alcohol use. The quality of studies was assessed using the Quality Assessment Tool for Quantitative Studies **(84)**, and found that 15 studies were of medium quality, 1 was of strong quality and 5 were of weak quality, mainly based on selection bias, low response rate and confounding variables. Overall, the review found that higher alcohol outlet density and increased exposure to alcohol marketing in the local community may be associated with an increase in alcohol consumption, especially among adolescents. However, they interpret their conclusions with caution, recommending that reducing alcohol outlet density is possibly beneficial. In addition, they conclude that evidence for licencing restrictions (including banning sales, and making changes to the hours, days) is inconclusive.

A systematic review by Aguileira and colleagues (2014) **examined the effects of road safety measures and their effects on traffic injuries**. The review included 22 studies, of which 8 examined the effectiveness of alcohol legislation on road traffic injuries and deaths. Of these 8 studies, only one study was related to the hours and says of sale. Specifically, the study examined the effect of the repeal of law related to the sale of alcohol on Sundays. Time series analysis found a 42% increase in alcohol-related fatal crashes on Sundays, following the revocation of the law related to alcohol sale on Sundays. Overall, the review found that changing behaviours of drivers, especially regarding speeding and drink-driving measures was most effective in reducing traffic injuries.

Wilkinson and colleagues conducted a systematic review on the **impact of changes to alcohol trading hours on alcohol consumption and alcohol-related harms (76)**. They identified 21 studies in the review, of which 14 examined the impacts of increased trading hours, 7 examined the impacts of restrictions on trading hours. Seven studies were categorised as robust and well-designed. Overall, the review found that reducing hours of on-premise alcohol sales late at night can substantially reduce the rates of violence. The review further found that increasing trading hours tends to result in higher rates of harm and conclude that evidence of effectiveness is strong enough to consider restricting late trading hours for bars and hotels as a means to reducing late night violence.

Another systematic review by Sanchez-Ramirez and colleagues **examined the impact of policies regulating alcohol trading hours and days of sale on specific alcohol-related harms** (assault, violence, motor vehicle crashes/fatalities, injuries, visits to the emergency room/hospital, murder, homicide/crime) **(77)**. Based on findings from 26 studies, they concluded that regulating times of alcohol sales and consumption can result in reductions in injuries, alcohol-related hospitalisation/emergency room visits, homicides and crime. However, the evidence was less compelling for the impact of alcohol trading policies on these outcomes, suggesting that further research on this is merited.

In a recent systematic review, Nepal and colleagues looked at the **effects of extensions and restrictions in alcohol trading hours on the incidence of assault and unintentional injury (78)**. The review was based on 22 studies, all of which were interrupted time series designs. They examined the effect of (a.) extension of trading hours in on-licence premises only and (b.) the restriction of trading hours on both on and off-licence premises. The quality of studies was assessed using the Effective Practice and Organisation of Care (EPOC) guidelines **(85)** and Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). The majority of studies were found to have low risk of bias of displacement, contamination, and confounding. Overall, the review found that extending trading hours was positively associated with increases in assault, unintentional injury, and drink-driving offences. In contrast, restricting trading hours resulted in decreases in incidence of assault and hospitalisation.

Evidence from evidence reviews

Three studies point to the proliferation of alcohol outlets and its influence on drinking. The first study emerges from the Brazilian city of Sao Paulo, where in 2002 it recorded the highest density of alcohol outlets ever **(79)**. The study examined the availability of alcohol in a densely populated residential area of suburban São Paulo, characterised by poverty and violence. It found 107 alcohol outlets in the area per 1,202 other (non- alcohol related) properties and suggests that outlet density could be calculated based on the number of outlets per kilometre of roadway; and the proportion of all properties that sold alcohol. The study hypothesizes that high alcohol outlet density may be related to the very high rates of violence in the city **(79).** However the study was exploratory in nature, unable to prove any association between alcohol outlet density and violence, and inferences of an association must therefore be interpreted with caution.

Another study in urban Tanzania conducted by Ibitoye and colleagues employed a systematic community mapping and participatory group approach to examine how alcohol outlet density and advertising may contribute to adolescent drinking in urban Tanzania. The study found a high density of alcohol outlets and outdoor advertisements, which was said to contribute to initiation and an increase in drinking among adolescents **(81)**. However, results should be interpreted on the basis that alcohol consumption among study participants was not measured, and therefore the effect of alcohol density and advertising on adolescent drinking cannot be quantified. However, the study does provide important insights from adolescents on the effects of structural factors such as alcohol outlet density on drinking or their intentions to drink.

Evidence from a record review by Duailibi and colleagues examined whether limiting the hours of alcoholic beverage sales in bars had an effect on homicides and violence against women in Diadema, Brazil **(80)**. The authors analyzed data on homicides (1995-2005) and violence against women (2000 - 2005) from population statistics in Diadema, (population 360 000) and police archives. They found that the restrictions on drinking hours (reducing closing times) were associated with a decrease of almost 9 murders per month (44%), and a decrease in assault of women, though the latter finding was not statistically significant **(80)**. The study is limited by the lack of demographic, social-economic changes that may impact on crime, and the data on women assault was limited by shorter time series and variable quality of reporting, making it difficult to attribute the reduction in assaults to the changed laws. In addition, it does not take account of multiple factors that may explain changes in homicide and focuses only on drinking restrictions.

In summary, the evidence from systematic reviews point to the widely accepted view that increased availability of alcohol, through increased alcohol-outlet density and hours of trading times is associated with an increase in alcohol use and alcohol-related harm.

This section of the review considered alcohol interventions as a pathway to reducing GBV (intimate partner physical and sexual violence and non-partner sexual violence).

Table 4: Interventions addressing alcohol and GBV

13 STUDIES SHORTLISTED OF INTERVENTIONS ADDRESSING ALCOHOL AND GBV

13 STUDIES

13 studies from a global evidence review – A RCT of the Women's Health CoOp intervention **(88)**; a RCT on impact of a brief peer-facilitated intervention (WHC) on women's drug use and IPV (89); a RCT of relationship power, communication, and violence among couples **(90)**; a cluster RCT of the impact of Stepping Stones **(24)**; a cluster RCT of the Stepping Stones and Creating Futures intervention **(91)**; a RCT of the Violence Alcohol Treatment Zambia (VATU) **(92)**; a RCT of a college women's parent-based intervention **(93)**; a RCT on the impact of a brief drinking intervention of college women's sexual violence (94); a RCT of a sexual assault and alcohol risk reduction intervention **(95)**; a systematic review of alcohol interventions, alcohol policy and IPV **(96)**; a systematic review of treatment models for substance using offenders of IPV **(97)**; a systematic review of interventions targeting men's alcohol use and family relationships in low-middle income countries **(98)**; a longitudinal analysis of cross-sectional time series data examining the associations between alcohol outlet density and domestic violence rates **(99)**.

9 RCT/QUASI-EXPERIMENTAL STUDIES

- **1** RCT- Women's Health CoOp intervention (2011) **(88)**
- **1** RCT on impact of a brief peer-facilitated intervention (WHC) on women's drug use and IPV **(89)**
- **1** RCT of relationship power, communication, and violence among couples (2015) **(90)**
- **1** cluster RCT of the impact of Stepping Stones (2008) **(24)**
- **1** cluster RCT of the Stepping Stones and Creating Futures intervention (2020) **(91)**
- **1** RCT of the Violence Alcohol Treatment Zambia (VATU) intervention (2020) **(92)**
- **1** RCT of a college women's parent-based intervention (2010) **(93)**
- **1** Impact of a brief drinking intervention of college women's sexual violence (2011) **(94)**
- **1** RCT of a sexual assault and alcohol risk reduction intervention (2015) **(95)**

1 CROSS-SECTIONAL TIME SERIES DESIGN

- **1** longitudinal analysis of alcohol outlet density and domestic violence **(99)**

3 EVIDENCE REVIEWS

- **1** systematic review of alcohol interventions, alcohol policy and IPV (2014) **(96)**
- **1** international review of interventions to reduce intimate partner violence perpetration among people with substance use disorders **(97)**
- **1** systematic review of interventions targeting men's alcohol use and family relationships in low-and middle-income countries **(98)**

OVERALL FINDINGS

Good evidence: There is good evidence from systematic reviews of the effectiveness of interventions that reduce alcohol availability to reduce both alcohol consumption and alcohol-related harm.

Effectiveness of the interventions:

Overall, there is good evidence from both RCTs and systematic reviews for the effectiveness of alcohol interventions in reducing GBV outcomes. Specifically, the evidence suggests that working with couples to intervene on issues of alcohol misuse and violence, as well as intervening with men through gender transformative programme may be particularly beneficial. Where good evidence exists for reducing GBV through alcohol and/or substance use interventions, these come from Southern Africa. However, there is also limited evidence for the effectiveness of structural alcohol interventions in reducing GBV outcomes via alcohol interventions.

Evidence from Randomised Control Trials (RCTs)

Three South African based RCT's evaluated the impact of **Women's Health Co-operative (WHC) intervention** on excessive alcohol use, sexual and physical violence, drug use respectively **(88, 89, 100)**.

The first, a community based RCT, examined the impact of WHC among sex workers and non-sex workers who used alcohol excessively. At six month follow-up, non-sex workers reported significantly less drinking in the previous 30 days, were significantly less likely to meet DSM-IV criteria for alcohol dependence, were more likely to use a condom at last sex with a main partner, and were significantly less likely to report sexual abuse by a main partner. In addition, sex workers reported significantly less physical violence from their main partner **(88)**.

The second RCT, a brief peer-facilitated intervention, evaluated the impact of WHC on women who used drugs and experienced IPV, and found a positive impact on drug use, but no impact on IPV experience at 12 months **(89)**. The study did not measure an alcohol outcome but is included here for completeness in assessing the effectiveness of the WHC on substance use and IPV.

A third RCT, compared the WHC for women alone, with adaptions of the WHC i.e. one adaptation with men and their female partners together in a couple's intervention (Couples Health CoOp [CHC]) and a gender-separate intervention (Men's Health CoOp/Women's Health CoOp [MHC/WHC]) **(90, 100)**. Overall, compared to the women only component, women in the CHC, and those in the MHC/WHC arms reported less violence at six months post baseline. In addition, both men and women reported significantly less alcohol use.

A RCT in Zambia, **the Violence Alcohol Treatment Zambia (VATU)** intervention, which adapted the Common Elements Treatment Approach (CETA) examined the effectiveness of an evidence-based, transdiagnostic intervention addressing both alcohol abuse and gender-based violence on women's experiences of IPV and their male partner's alcohol abuse **(92)**. This intervention was delivered to 248 couples over 6 to 12 weekly sessions by lay counsellors, and was evaluated in a two arm RCT. The evaluation found significant reductions in alcohol use, harmful use, and perpetration of IPV among men. Among women, it also found significant reductions in overall alcohol use, harmful alcohol use, and experiences of physical and sexual IPV. Overall, the intervention impacted positively on the mental health of both men and women in the couples, with both reporting significantly reduced symptoms of depression and post-traumatic stress disorder (PTSD). The success of this intervention points to the promise of working with high risk couples to address the co-occurring problems of alcohol abuse and violence.

Two RCT's from South Africa showed positive impacts on alcohol use. The first RCT, **Stepping Stones**, a 50-hour intervention, which was designed to target HIV incidence, IPV reduction, unwanted pregnancy, sexual practices, depression, and substance misuse, showed (among other outcomes) significant reductions in men's alcohol use and poor mental health at 12 months follow up **(24)**. The second RCT, **Stepping Stones and Creating Futures** intervention, a participatory gender transformative and livelihoods strengthening program was designed to reduce

IPV perpetration and violence experience. It was delivered over 21 sessions, each approximately 3 hours long, delivered twice a week to single sex groups of approximately 20 participants. At endline, the intervention showed positive impacts, with reductions in both alcohol use and men's perpetration of IPV at 12 and 24 month follow up in the intervention arm compared to the control arm **(91)**. The success of both these interventions point to the promise of approaches with gender transformative components targeting men in reducing both violence perpetration and alcohol use and should be explored alongside other measures to reduce alcohol use.

Apart from the six interventions mentioned above from SSA, the majority of alcohol interventions that impact on GBV outcomes emerge from outside SSA, and largely from the global North. For example, a randomized controlled trial targeting alcohol use and sexual assault risk among college women at high risk for victimization used a web-based combined **sexual assault and alcohol use risk reduction (SARR) intervention** among 207 college women. The intervention reduced sexual assault experiences (rape and attempted rape) for women who engaged in heavy episodic drinking. By the end of the intervention, women with higher incidence and severity of sexual assault at baseline engaged in less heavy episodic drinking compared to the control condition at the 3-month follow-up.

Another study from the United States assessed the **impact of a motivational interviewing (MI)** brief alcohol intervention and prior victimization on alcohol-involved sexual victimization experiences among 229 first-year female college students **(94)**. The evaluation found a reduction in alcohol use for all conditions, and specifically a reduction in sexual assault experienced in the MIFB arm. However, the study is limited by its single self-reported measure of pressured or forced sex in the context of alcohol-involved incapacitation. This may have led to an under-reporting of alcohol-involved violence experienced and other types of sexual violence. It is also limited by a short follow up of only 3 months.

Testa and colleagues tested the effectiveness of a **parent-based intervention (PBI)** to reduce the incidence of alcohol-involved sexual victimization among first-year college students in the USA **(93)**. The intervention was designed to increase communication (alcohol-specific and general) between mother and daughter. It reached female graduating high school seniors and their mothers from the community and randomly assigned to one of four conditions: Alcohol PBI (n = 305), Enhanced Alcohol + Sex PBI (n = 218), Control (n = 288) or Unmeasured Control (n = 167). The evaluation found that either standard or enhanced PBI, was associated with lower incidence of incapacitated rape in the first year of college compared to the control group. The intervention had positive effects, by increasing mother-daughter communication, which predicted lower incidence of first semester heavy episodic drinking, resulting in lower rates of alcohol-involved sexual victimization in the first year of college. The intervention was however limited by its relatively modest effects, as it did not reduce overall heavy episodic drinking, and the fidelity of the intervention implementation was difficult to establish.

The Integrated Violence Prevention Treatment (IVPT) intervention, which targeted men and women in treatment for substance use disorders, was tested in a randomized controlled trial (RCT) in the United States **(101)**.The intervention used a motivational interviewing approach and 5 therapy sessions. Despite decreases in cocaine use between baseline and 3-month follow-up for both conditions, and a significant decline in alcohol use in the IVPT, no impacts were found for women's experience of IPV.

Evidence from systematic reviews/longitudinal study

Giusto and Puffer conducted a **systematic review of interventions targeting men's alcohol use and at least one family outcome** (IPV/GBV days without family dysfunction, quality of family and social relationships and parent and child mental health) in LMICs. The review was based on 9 studies, of which only one primarily focused on synergistically improving drinking and a related family-level outcome (IPV). Overall, they found that in 6 of the 9

studies there were modest improvements in drinking and family outcomes **(98)**. However, it did find that motivational interviewing and behavioural techniques were beneficial for reducing alcohol use, while gender-transformative approaches were related to reduced IPV and more equitable gender norms.

Another systematic review by Wilson and colleagues examining the **effectiveness of treatment models for substance using offenders of IPV**, found some positive effects of a brief alcohol intervention as an aide to batterer treatment, and positive effects of brief interventions with non-alcohol dependent youth, but effects were often not sustained **(96)**. The same systematic review examined associations of the effectiveness of structural interventions (alcohol interventions/ policies) on IPV reduction **(96)**. It found weak or no evidence for alcohol price changes on IPV. It also found that studies of community-level policies or interventions (e.g., hours of sale, alcohol outlet density) showed weak evidence of an association with IPV. However, the authors concede that this is due in large part to (a) a small literature base examining the effect of structural interventions on alcohol use; (b) using an alcohol-related IPV and IPV measure that was not alcohol-related. It is also notable that the majority of individual studies that are cited emerge from the global North, which do not take account of the context-specific realities of alcohol outlet density or hours of sale in SSA (e.g. proliferation of informal alcohol outlets and poorly implemented outlet trading times). This underscores the need for stronger designs and more studies to be conducted on the effectiveness of structural alcohol interventions on alcohol related GBV in the global South.

Evidence from a longitudinal cross-sectional time-series design (included as an exception to the eligibility criteria) examined the **association between alcohol outlet density and domestic violence in Australia**. In keeping with findings from many studies, it found that increased alcohol outlet density was significantly associated with increases in domestic violence over time, with a particularly increased effect for outlets that sold packaged liquor **(99)**. This highlights the need to look more closely at alcohol outlet density in relation to alcohol use and its related harms in SSA.

DISCUSSION

In the last two decades there has been growing recognition and scientific evidence of the role of alcohol as a significant driver of gender-based violence. This evidence review has revealed this association **(9, 11, 102)**, particularly in SSA. However, it has also revealed the limited evidence from SSA of high-quality evaluations of structural interventions to prevent (a.) alcohol abuse, (b.) alcohol related GBV. Notably the evidence base is limited in evaluations to assess the effectiveness of interventions to reduce alcohol availability, particularly those recommended by WHO to reduce alcohol-related harm. However, evidence from systematic reviews found that reducing alcohol availability by restricting alcohol outlet densities (AOD) and outlet trading times (OTT) was associated with reduced alcohol consumption and its related harms. Furthermore, the review reveals some evidence of the effectiveness of couples and gender transformative interventions for reducing alcohol related GBV. This suggests that a useful approach to addressing alcohol-related GBV could be through a suite of structural, couples, and gender transformative programmes.

This review has found good evidence from systematic reviews for the association between reducing alcohol availability (AOD and OTT) and alcohol-related harm **(66-69, 72, 79, 80)**. However, evidence for this emerges largely from the global North. In line with this review's focus i.e. examining studies assessing the effectiveness of reducing **availability** as a means to reduce alcohol abuse and alcohol-related GBV, the dearth of literature suggests that more work is required to assess the effectiveness of structural interventions in the global South. This will enable a realistic and useful lens through which to plan prevention and intervention efforts that address these intersections.

In addition, the review indicates that there is stronger evidence for the effectiveness of reducing alcohol outlet density as a means of reducing alcohol use and its related harms compared to restricting trading hours **(74, 82)**. Simultaneously, the timing of this review coincides with an unprecedented time in the history of alcohol control (COVID-19 related alcohol restrictions), where available studies indicate clear associations between reductions in outlet trading times through complete and partial sales bans and reductions in alcohol-related harms **(62, 65, 103)**. Therefore, conducting further research on alcohol outlet density and outlet trading times is merited.

Although the RCT is a gold standard in evaluation research design, it is noteworthy that this design may have limited use for assessing the effectiveness of structural interventions in reducing alcohol use and its related harm. One suggestion is that research designs that lend themselves to measuring the complexities of structural interventions (AOD and OTT) in relation to alcohol use are needed. However, the lack of data on AOD and the thwarted implementation of outlet trading times, and the dearth of evidence of AOD reduction interventions worldwide means that it not really known if these interventions work on their own. Despite this, the available research shows clear positive associations between increased alcohol outlet density and outlet trading times and increased alcohol use and its related harms and merits further research, particularly in the global South.

The findings from available studies in the 4 Southern African countries on structural interventions to address alcohol and its related harms indicate that despite the presence of legislation and policy frameworks, **enforcement** of alcohol control remains a challenge in SSA. In addition, a common challenge across the SSA context is the role of industry involvement in alcohol policy, which must be acknowledged and addressed by key decision makers **(13-15)**.

Finally, the role of community participation in policy implementation and enforcement is largely under-explored and therefore limited evidence of its contribution is available. Public health and development literature cite community engagement and participation as a key element for meaningful and sustainable change towards more enabling environments within which individuals and communities can thrive. Within a health promotion and asset-based development framework, partnerships with communities need to include all aspects including identifying the issue and monitoring implementation **(104)**. Involving communities in research in their community contributes to building the social capital of a community to take ownership, identify solutions and participate in remedial action. In the context of limited human, financial and infrastructural resources of countries in the global South, this paradigm is critical for sustainable implementation of health interventions.

Community involvement and partnership also maximises the ethical conduct of the research; can decrease the gatekeeping by communities; and can improve the uptake of the findings of the research. Importantly, lack of community involvement in the research can result in overlooking the potential consequences of the research e.g. cultural appropriateness **(105)** Establishing trust, which includes **reciprocal** communication; being **relatable** e.g. context- specific dress code and local language; mindfulness of importance of **relationships** and **respect** for customs and traditions (4 R's) is a critical element for conducting and the uptake of research **(105)**.

Within the context of alcohol regulations, empowering and partnering with communities to participate in research that identifies their local 'reality' and barriers in the development, implementation, monitoring and enforcement of local level regulation of alcohol, could lead to better outcomes of regulation.

Investigating ways in which communities can take action to promote health and prevent alcohol-related harm should be a critical element of a national strategy to reduce alcohol attributable harm as recommended in the WHO 2010 Global Strategy. In a review of alcohol policies and its implementation in SSA, Ferreira-Borges and colleagues argues that popular community mobilisation and support is a necessary ingredient for enabling enforcement and maintenance of a regulatory regime **(106)**. Community participation offers the opportunity to translate national, provincial and regional or district policies and regulations at a local authority level. This can contribute to the creation of social environments that shifts trading practices and social drinking norms to support positive individual behavioural change.

It is the contention of this review that formalising community participation in routine data collection and analysis will empower, skill and increase community ownership of the solutions to impact the effectiveness of reducing alcohol availability (AOD and OTT) on alcohol attributable harm. This will influence local authority decisions about regulations related to alcohol outlet density and trading hours.

LIMITATIONS

There were a number of limitations in the review. It was not a systematic review, but it did follow the principles of a systematic review, and therefore covers as many studies as possible in SSA. The review did not consider evidence from qualitative studies in its search strategies. However, wherever possible in-country evidence from qualitative research and its overarching thematic findings have been included in the background of the report. In the absence of a gold standard to measure the effectiveness of structural interventions (AOD and OTT), the review employed the RCT and quasi experimental designs as the gold standard. However, it must be acknowledged that other kinds of research designs and methods could also lend themselves to measuring the effectiveness of structural interventions in reducing alcohol and its related harms. Nonetheless, while future work should focus on developing a methodological gold standard for this work, existing evidence points to a definite increase in alcohol use and its related harms with increases in AOD and OTT.

RECOMMENDATIONS

Based on this evidence review of alcohol availability (AODs and OTT), as well as its association with Gender Based Violence in sub-Saharan Africa, the recommendations for donors, implementers and researchers are as follows:

For donors:

1. INCREASE INVESTMENT IN RESEARCH ON THE ASSOCIATION BETWEEN ALCOHOL AND GBV IN GLOBAL SOUTH

Given the growing recognition and emerging research evidence on alcohol as a driver of gender based violence, donors need to substantially increase investment in research on alcohol and its association with gender based violence in the global South; including rigorous evaluation of such interventions that seek to address these associations. A number of key areas for donors are identified:

a) Fund scale up of existing interventions that have been shown to reduce alcohol use and GBV (e.g. couples programmes, gender transformative programmes);
b) Fund evaluations of structural interventions to reduce alcohol use and its related harms;
c) Fund the testing of effective interventions (e.g. couples and gender transformative programmes) combined with structural interventions as part of a comprehensive approach to reduce alcohol related GBV;
d) Fund testing of local and context specific interventions which have not yet been robustly evaluated, or from which broader lessons for the field can be learned;
e) Adopt best practice research methods and data collection to measure the effectiveness of structural interventions on alcohol use and GBV; and

f) Fund rigorous research on the effectiveness of reducing alcohol outlet density and outlet trading times on alcohol use and GBV.

2. INCLUDE COMMUMITIES AS PART OF EVIDENCE COLLECTION AND DECISION-MAKING PROCESSES

A key recommendation of this review, in line with WHO recommendations is to include community action as a strategy of governments as part of a package interventions to reduce alcohol attributable harm.

For programme implementers:

a) Through community programming, sensitise communities to the association between alcohol and GBV;
b) Empower communities with knowledge and skills to take responsible and collective action on alcohol regulations;
c) Involve local communities in participatory mapping of data (quantitative and qualitative) on the regulation of alcohol in their communities;
d) Recognise the role, value and influence of community action in influencing local authority decisions about alcohol outlet density and trading hours.

For researchers:

3. INCREASE RIGOUR OF RESEARCH

a) Improved quality of routinely collected data by liquor authorities at provincial level on AOD (licenced and unlicenced outlets) and outlet trading times, including evaluations of the effect of changes in these AOD and outlet trading times on alcohol consumption and GBV;
b) Robustly designed and implemented qualitative research that is published on how regulations related to alcohol outlet density and outlet trading times are experienced (e.g. contravention of official trading times, impact of thwarted implementation);
c) Testing best practice research and data collection to measure the effectiveness of structural interventions on alcohol use and GBV.

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APPENDIX A: LIST OF ALCOHOL AND GBV LEGISLATION AND POLICIES IN SOUTH AFRICA, BOTSWANA, NAMIBIA AND ZIMBABWE

South Africa

List of Alcohol policies

- Liquor Act, 59 of 2003
- Gauteng Liquor Act, 2003
- W Cape Liquor Bill of 2005
- Norms and Standards in Terms of the Liquor Act, 59 of 2003 (2015)
- National Liquor Norms and Standards, 2014

List of GBV policies

- Constitution of the Republic of South Africa 108 of 1996
- The Bill of Rights under the Constitution
- Domestic Violence Act of 118 of 1998
- Convention on the Rights of the Child that ensures the recognition of children's rights
- Beijing Declaration and Platform for Action, 1995
- Protocol to Prevent, Suppress and Punish Trafficking in Persons, 2000
- Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, 2002
- Convention on the Rights of Persons with Disabilities, 2007
- the Children's Act 38 of 2005
- the White Paper on Safety and Security
- The Child Justice Act No 75 of 2008
- Criminal Law (Sexual Offences and Related Matters) Amendment Act 6 of 2012
- Criminal Law (Sexual Offences and Related Matters) Amendment Act 5 of 2015
- Prevention and Combating of Trafficking in Persons Act 7 of 2013
- Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000
- the Integrated Social Crime Strategy
- GBV policy and strategy framework for higher education university and college campuses
- Life Orientation Strategy for Basic Education and higher education
- National Strategic Plan on Gender Based Violence and Femicide 2020
- Domestic Violence Amendment Bill 2020
- Criminal justice reform bill 2020
- Higher Education GBV Policy and Strategy Framework to develop an integrated model for managing sexual and gender-based violence
- The Plan of Action on Violence against Women and Children
- 365 Days Strategy of No Violence Against Women and Children
- National Guidelines, Medical Management of Rape
- Global: Guidelines for Medico-Legal Care for Victims of Sexual Violence, WHO, 2004
- The Centre for Disease Control - Sexual Assault or Abuse of Children, 2015
- Trafficking in Persons Act

Botswana

List of Alcohol policies

- Trade and Liquor Act of 1986
- Trade Act, 2003 (Act No. 5 of 2004)
- Levy on Alcohol Beverages Fund Order,2008
- National Alcohol Policy, 2010
- Traditional Beer Regulation, 2011

List of GBV policies

- Domestic Violence Act in 2008
- National GBV Strategy 2015-2020

Namibia

List of Alcohol policies

- Liquor Act 6 of 1998

List of GBV policies

- The Combating of Domestic Violence Act 4 of 2003
- The Combating of the Rape Act 8 of 2000,
- The Protocol of the African Charter on Human and People's Rights of Women in Africa
- SADC Protocol on Gender Development

Zimbabwe

List of Alcohol policies

- Traditional Beer Act 14:24
- Liquor Act (Chapter 14:12)
- Food Standards (Alcoholic Beverages) Regulations 2001

List of GBV policies

- Domestic Violence Act 2006