
Report from a round-table
meeting with
nongovernmental
organizations and health
professionals on harmful
use of alcohol



**World Health
Organization**

Geneva, 24 and 25 November 2008

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meeting with
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Executive summary

The meeting reported in this document was part of a broad consultation organized by the World Health Organization (WHO) for preparation of a draft global strategy to reduce the harmful use of alcohol. The meeting was chaired by Dr Benedetto Saraceno, Director of the Department of Mental Health and Substance Abuse at WHO. The aim was to determine how nongovernmental and health professional organizations can contribute to reducing the harmful use of alcohol by advocacy, the health sector response, community action, drink-driving policies and countermeasures, marketing of alcoholic beverages, harm reduction and reducing the public health impact of illegal and informal alcohol. The group also discussed ways of achieving more structured interactions at global level between the WHO Secretariat, nongovernmental organizations and health professionals. Representatives of 27 organizations and associations participated in the round-table meeting with members of the WHO Secretariat, and participants made short, general statements on behalf on 15 organizations.

The main points made by nongovernmental and health professional organizations concerning their contributions to reducing harmful use of alcohol are as follows:

Advocacy

- The essential elements of their work in this area are a message and a structure for delivering the message in a timely, effective manner.
- Key messages to be communicated include reducing the harm of alcohol, increasing awareness and commitment to change and implementing an effective strategy.
- WHO should address the contentious issues of harm versus benefits and examine guidance for low-risk drinking.
- The organizations are committed to increasing governments' understanding of the scale of the problem and the actions required to reduce harm.
- Grass-roots engagement is essential for advocacy.
- The organizations need to build capacity at regional level and promote interaction among regional and local actors.
- WHO should encourage Member States to engage with nongovernmental organizations and the health professions.
- The formulation of WHO guidelines for monitoring the harm caused by alcohol would be helpful for the organizations.
- WHO should develop training modules to help the organizations build capacity, in particular in countries with few resources.

Health sector response

- The organizations, with support from WHO and Member States, will increase the knowledge base of all health workers and promote screening for alcohol problems.
- They will promote a sector-wide approach for addressing alcohol problems.
- Brief interventions are well accepted as effective by health professionals, but more attention is needed to other forms of treatment.
- Treatment is only part of an overall strategy.
- Health professionals should clarify the link between individual problems and public health alcohol policy.
- The organizations are concerned about the rise in episodic heavy drinking among young people and the links to new products.
- They will advocate that governments correct the imbalance in their attention to illicit drugs and to alcohol, in which alcohol receives much less attention.

Community action

- The organizations have broad experience in community action, which is a key strategy for reducing alcohol-related harm.

- Community action is the life blood of nongovernmental organizations, for which building capacity and empowering communities to address alcohol problems are core elements.
- Local community action can be more successful than national action, partly because of a lack of national political will.
- Good practice for effective community action by nongovernmental organizations requires common goals and local autonomy for implementation.
- Self-help organizations are valuable resources for people and families affected by alcohol drinking.

Drink-driving policies and countermeasures

- The success of 'Mothers against Drink-driving' in achieving lowered blood alcohol concentrations in certain countries demonstrates the importance of nongovernmental organizations.
- They are committed to influencing the normative view of drink-driving and to promoting a lower blood alcohol concentration.
- They stressed that Member States should strengthen the enforcement of random breath testing and sobriety checks.
- The organizations are committed to a clear message of 'Don't drink and drive'.

Marketing of alcoholic beverages

- They are committed to monitoring alcohol marketing globally, especially by providing information on new styles of marketing.
- The organizations act as watch dogs of compliance with national regulations or bans on alcohol marketing.
- They are committed to helping Member States regulate alcohol marketing.
- As alcohol is marketed globally, the response must be global.
- The organizations working in education and training are committed to helping students think critically.
- They will continue working towards reducing the exposure of young people to both commercial and cultural alcohol marketing.

Harm reduction

- Health professionals stressed the meaning and limitations of harm reduction, giving as examples the treatment of heavy drinkers found drunk on the street or in police stations.
- Brief interventions are not considered to constitute a harm reduction approach because they are intended to help people drink less.
- Mutual self-help groups are committed to a whole-family approach.
- The evidence base for harm reduction measures such as designated driver and server training is considered weak.
- The organizations are committed to harm reduction measures based on evidence and focused on outcomes.

Reducing the public health impact of illegal and informal alcohol

- The organizations recommend that informal production and sale of alcohol be brought into formal structures, with communities in charge.
- Social movements, in particular women's groups, in developing countries can creatively reduce the supply of alcohol and reduce harm.

Following the WHO meeting, the nongovernmental organizations agreed to set up an information and communication platform called the 'Nongovernmental Organization Alliance for a Global Strategy on Alcohol', to ensure better communication among WHO, nongovernmental organizations and health professionals, on ways to reduce alcohol-related harm.

Report of the meeting

1. Introduction

Opening of the meeting

Dr Benedetto Saraceno, Director of the Department of Mental Health and Substance Abuse at WHO, welcomed the participants to the round-table meeting of representatives of nongovernmental organizations and health professionals with WHO Secretariat. He said that the consultation was part of the follow-up by WHO called for in World Health Assembly resolution (WHA61.4) on “Strategies to reduce the harmful use of alcohol”, adopted in May 2008.

Dr Saraceno said that the meeting would focus on how nongovernmental and health professional organizations could contribute to reducing the harmful use of alcohol in seven areas: advocacy, the health sector response, community action, drink-driving policies and countermeasures, marketing of alcoholic beverages, harm reduction and reducing the public health impact of illegal and informal alcohol. They would also explore means for achieving more structured interaction at global level among nongovernmental and health professional organizations and WHO in relation to the harmful use of alcohol. The scope and purpose (Annex1) and the programme (Annex 2) of the meeting are attached to the report.

Dr Saraceno then introduced the WHO Secretariat and invited participants to introduce themselves, giving their affiliations. The list of participants is attached as Annex 3.

Dr Ala Alwan, Assistant Director-General, Noncommunicable Diseases and Mental Health, outlined the importance of alcohol as a global determinant of health. He said there was sufficient evidence for action but that much of the evidence for effective strategies was from developed countries. Noncommunicable diseases accounted for 60% of all deaths, and an action plan to tackle those diseases had been endorsed in early 2008. Alcohol was one of four main risk factors for noncommunicable diseases. Discussions on those diseases had multiplied in all six WHO regions, and alcohol was consistently cited as an important contributor to the burden of disease.

Dr Alwan thanked all those present for participating in the consultation. He said that a draft global strategy on the harmful use of alcohol would be drawn up in collaboration with Member States, taking into consideration, when appropriate and relevant, the outcome of the consultations with intergovernmental, health professional and nongovernmental organizations and economic operators.

Implementation by the WHO Secretariat of World Health Assembly resolution “Strategies to reduce the harmful use of alcohol”

Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse, Department of Mental Health and Substance Abuse, introduced World Health Assembly resolution WHA61.4, which calls on the Director-General of WHO to prepare a draft global strategy to reduce harmful use of alcohol (Annex 4). The planned process of implementing the resolution and preparing the draft strategy involved two stages. The first consisted of broad consultation, including a Web-based consultation (October–November 2008), a round-table meeting with economic operators (6 November 2008), the present meeting with health professional and nongovernmental organizations and a consultation with selected intergovernmental organizations (in 2009) on ways in which participants could contribute to reducing the harmful use of alcohol.

The second stage would consist of collaboration and consultation with Member States in preparation of the draft global strategy. That would involve regional technical consultations with Member States in all WHO regions (February–April 2009), preparation of a draft by the WHO Secretariat, submission of the draft to the Executive Board (January 2010) and subsequent submission to the Sixty-third World Health Assembly in May 2010.

The reports from the round-table meetings and the intergovernmental consultation would be posted on the WHO website (http://www.who.int/substance_abuse/) and would be available for consultations between WHO and Member States during the regional meetings in the first half of 2009.

Discussion

A brief discussion was held on how nongovernmental organizations and health professionals could communicate and interact more effectively with Member States. Two main channels were identified: national and regional. Member States could send representatives of nongovernmental organizations and health professionals as delegates to regional meetings, and those organizations that are in official relations with WHO could make statements at regional and international meetings. The issue of better interaction between nongovernmental organizations and WHO was scheduled for discussion later in the meeting.

2. Statements from representatives of organizations and associations

Representatives of 15 organizations, listed below, made short general statements on ways in which they could contribute to reducing the harmful use of alcohol. The written statements are reproduced in Annex 5.

- Al-Anon
- Alcoholics Anonymous
- Alcohol Policy Youth Network
- Asia Pacific Alcohol Policy Alliance
- Canadian Centre on Substance Abuse
- Eurocare
- Global Alcohol Policy Alliance
- International Council of Nurses
- International Federation of Medical Students' Associations
- International Network on Brief Intervention for Alcohol Problems
- International Society for Addiction Medicine
- IOGT International
- Lions Clubs International Headquarters
- World Medical Association
- Worldwide Organization for Women

The Youth Non-governmental Organization welcomed the mention of 'youth' in several of the general statements and emphasized the need to raise awareness in Member States of the important contribution that youth can make to reducing alcohol-related harm.

3. Reducing the harmful use of alcohol in selected areas

Advocacy

Statements on this topic were made on behalf of Eurocare, the European Alcohol Policy Alliance and the Global Alcohol Policy Alliance (Annex 6). In the ensuing discussion, it was agreed that advocacy has two essential elements: a message and a structure for delivering the message in a timely, effective manner. Nongovernmental organizations convey various messages, such as reducing alcohol-related harm, increasing awareness and commitment to change, implementing effective alcohol strategies and promoting low-risk drinking. An example given was the European-wide day addressing fetal alcohol syndrome, which emphasizes the risks to the fetus of drinking during pregnancy.

A number of challenges were identified. Alcohol is an important risk factor for health problems, but it also has a social and cultural role. Participants agreed that more specific guidance on

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low-risk drinking from WHO would be helpful. An important barrier to a clear message is disagreement about harms and benefits, and the nongovernmental organizations and health professionals suggested that a statement from WHO on this issue would also be helpful. In response, WHO cited mechanisms such as the WHO expert group, which could examine such issues. WHO noted, however, that the level of risk can differ by country. Some participants raised the concern that messages with regard to alcohol are aired in countries with strong alcohol marketing, in contrast to other products, such as illicit drugs and tobacco. A fundamental barrier is that some governments do not consider harmful alcohol use to be a problem that requires substantial action. Therefore, the advocacy message should increase awareness about the scale of the problem and the actions necessary to reduce it.

Participants agreed that the advocacy message should be delivered by nongovernmental organizations, in particular to health professionals and the wider community at local and regional levels, to Member States and internationally. The experience of nongovernmental and health professional organizations in delivering such messages has shown the importance of grass-roots involvement, and participants stated that “The more local the action, the more successful the advocacy work”. Capacity should be built at regional level, and interaction between regional and local actors is needed. Participants suggested that WHO provide support, such as encouraging Member States to engage with nongovernmental organizations and health professionals and to facilitate access to evidence for effective policies for implementation and enforcement. Guidelines for monitoring alcohol-related harm and training packages for regional and local dissemination, in particular in countries with few resources, would help build capacity in both governments and nongovernmental organizations.

Health sector response

Participants acknowledged that the health sector is important in improving understanding about the alcohol problem, in providing early intervention and treatment and in primary prevention; however, health-care providers show little engagement in alcohol problems. Participants recognized the need to increase the capacity of health-care providers by increasing their knowledge and by systematic screening for alcohol problems. The entire health sector should be involved, so that “Every door is the right door” for addressing these problems. Participants acknowledged that good information is available on how to reduce harm and on the costs of alcohol problems to health care. Some problems, such as fetal alcohol syndrome and drink-driving, are clearly preventable. Alcohol-related injuries were seen as an important concern for health professionals and nongovernmental organizations, as they affect both the drinker and other people.

Participants noted that brief interventions are considered to be effective by health professionals, but less attention is paid to other forms of treatment. The relationship between treatment services and self-help organizations could be strengthened, but it was agreed that “We will not treat our way out of the problem”—indicating that treatment is only part of an overall strategy. Health professionals stressed the link between individual problems and public health but said that governments did not appear to understand that link. Nongovernmental organizations should bring these issues to the attention of Member States and to the public. Some medical associations have taken a strong position on alcohol in public health policy, and others were encouraged to do likewise. Concern was raised about the rise in episodic heavy drinking (known as “binge drinking”) among young people and the link with new products. Several participants stressed that the common good of society should take priority over commercial interests.

Some participants stressed that education is an important part of primary prevention. Others, while accepting that education is useful, stressed the need for regulation and enforcement of laws. Some nongovernmental organizations noted that there was little evidence for the effectiveness of education. The health professional and nongovernmental organizations expressed concern about the imbalance in the attention paid by some governments to illicit drugs and to alcohol, with alcohol receiving much less attention.



Community action

Statements on this topic were made on behalf of Eurocare and the Global Alcohol Policy Alliance (Annex 7). In the discussion, the importance of nongovernmental organizations in community action was illustrated by examples from Cambodia, Canada, Sri Lanka and the United States of America. Responses to community needs and capacity-building bring about significant changes in policy and a reduction in the harm caused by alcohol. Community action was seen as the life blood of nongovernmental organizations, their role being to provide access to solid facts, to empower communities, to build capacity in using the media and in thinking strategically and to set clear policy goals. The experience of nongovernmental and health professional organizations is that local community action can be more successful than national action, partly because of a lack of national political will. Even small projects can improve the link between solutions and empower the community.

Self-help organizations can be a valuable community resource for people and families affected by drinking. Participation in such support programmes can improve the lives of individuals. Good practice to ensure effective community action includes setting common, clear goals and ensuring that each local community decides how best to implement the goals in accordance with its needs. WHO noted that while community action and advocacy had been discussed separately at the meeting, they are in reality intricately interlinked.

Drink-driving policies and countermeasures

A statement on this topic was made on behalf of Eurocare (Annex 8).

Dr Margie Peden, Coordinator, Unintentional Injury Prevention, Department of Injuries and Violence Prevention at WHO, described the significant risk posed by alcohol consumption in relation to road deaths and injuries worldwide. In response to the growing road safety crisis, WHO and the World Bank had published a report in 2004 which showed the magnitude of the problem, the risk factors and the interventions necessary to reduce road deaths and injuries. She said the evidence shows that all blood alcohol concentrations increase risk over that associated with zero blood alcohol, and the risk for road traffic deaths and injuries increases with the blood alcohol concentration. Dr Peden said that good evidence was available on which strategies are effective, the enforcement of low blood alcohol concentration limits being the most effective. Participants noted that universal prevention policies could also reduce drink-driving, and WHO fully concurred.

The success of the nongovernmental organization Mothers against Drink-driving (MADD) in lowering blood alcohol concentrations in certain countries was given as an example of the importance of nongovernmental organizations in reducing harm. These organizations and health professionals are also committed to influencing the normative view of drink-driving and in promoting a lower blood alcohol concentration. It was agreed that random breath testing is the most effective means for reducing alcohol-related road deaths and injuries but can be costly. The expectation that the law would be enforced was seen as a deterrent. Many participants said that their experience had shown that enforcement and timely penalties were often lacking and varied among countries; several examples were discussed. The nongovernmental organizations stressed that Member States must strengthen random breath testing and sobriety checks. The 'graduated licence' approach for new drivers used in Canada was reported to be very successful.

Combined roadside testing for alcohol and illicit drugs was discussed. Participants considered that alcohol tends to be underemphasized in combined testing. Furthermore, illicit drugs can stay in the system for several days.

Participants expressed concern about mixed messages regarding drinking and driving. Industry messages such as "Don't drive drunk" or "Drink, don't drive" can be more ambiguous than the agreed message from nongovernmental organizations and health professionals, which is "Don't drink and drive". Communicating this clear message will continue to be an important activity for nongovernmental organizations.

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Marketing of alcoholic beverages

Statements on this topic were made on behalf of Eurocare and the Global Alcohol Policy Alliance (Annex 9). Several nongovernmental organizations said that they were committed to monitoring alcohol marketing at global level, especially new styles of marketing. Examples of such monitoring in Europe, North America and the Pacific region were given. The nongovernmental and health professional organizations expressed concern about self-regulation. They noted that research has shown that producers can be compliant with codes yet continue to affect youth, there are many loopholes in self-regulation, enforcement is weak and there are no serious penalties. Some participants said that lessons should be learnt from experience with the tobacco industry, for which self-regulation did not work. Bans on alcohol advertising have been shown to be effective in some countries.

Nongovernmental organizations can act as watchdogs for compliance with national regulations and bans on alcohol marketing, as demonstrated by a French nongovernmental organization which pursued court cases in which breaches of French laws restricting alcohol marketing were observed. Nongovernmental organizations are committed to helping Member States set standards for regulating alcohol marketing. Youth nongovernmental organizations are particularly well placed, given the exposure of young people to alcohol marketing and the strong links to harmful use of alcohol. Sponsoring by alcohol companies of popular entertainment such as sport was mentioned in particular. Youth nongovernmental organizations are committed to assisting Member States in finding a systematic approach to alcohol marketing. Some participants, noting that alcohol is marketed at global level, said that a global response was necessary.

Different nongovernmental organizations have different emphases, some being more active in education and training and others covering policy. Participants whose organizations work mainly in education and training concentrate on helping students to think critically and to make better decisions about alcohol. Teaching media resistance and counter-advertising was considered useful, as in the case of tobacco. These are, however, costly activities for nongovernmental organizations.

'Cultural marketing' of alcohol reflects individuals' relationship with alcohol and interactions and relationships with others in society. Several examples were given by nongovernmental organizations. In a social marketing campaign in New Zealand with a large budget, an attempt was made to change the culture of drinking; however, this had no impact on behaviour, even though the messages were well received. A local wine festival in Europe, which was initially accepted by the community, had to be stopped because of a rise in alcohol-related problems. Some participants remarked on the 'alcoholization' of social events, many of which are centred around alcohol or created as drinking events. Alcohol advertising also influences cultural events. Therefore, nongovernmental organizations will continue to work to reduce the exposure of young people to both commercial and cultural alcohol marketing.

Harm reduction

Statements on this topic were made on behalf of Eurocare and the World Association of the Clubs of Alcoholics on Treatment (Annex 10). Health professionals stressed the importance of understanding the meaning of 'harm reduction'. The term is used mainly in treatment for drug use, in which the aim is to reduce harm but not use. Treatment for alcohol problems, such as brief interventions, was not considered to constitute a harm reduction approach because the aim is to help people drink less. The experience of the nongovernmental organizations and health professionals is that alcohol harm reduction is used mainly in compromised situations, such as for heavy drinkers on the street and people who are drunk in police stations. The Canadian nongovernmental organizations have avoided use of the term 'harm reduction' and have reached more consensus in tackling alcohol harm.

Mutual self-help groups use a 'whole family' approach, which can involve the extended family. In some nongovernmental organizations, this becomes an active citizen movement in a community. These organizations expressed their willingness to expand the programmes in other regions. Many of the self-help groups use an abstinence model, while others use a harm reduction approach.

Some nongovernmental organizations reported that designated driver schemes, a harm reduction measure, gave out mixed messages. The evidence for the efficacy of designated driver and server training in reducing harm was questioned by some participants. Adding a supplement to beer to reduce the risk for brain damage of people at particularly high risk was mentioned as a possible harm reduction measure. While the meaning of harm reduction varies by country, the participants agreed that what was important was that the measures used be based on evidence and focused on outcomes.

Reducing the public health impact of illegal and informal alcohol

The discussion centred on examples of home brewing in some countries, many of which are legal, such as in Canada, where students use legal loopholes to make cheap alcohol quickly. An example was given in which an alcohol product was diluted by bars and clubs which caused mistrust among young people and increased drinking in the street. Participants considered that in most countries home brewing is done on a much smaller scale than industrial production. Some participants highlighted the importance of recognizing that alcohol has toxic effects, whether it is produced industrially or at home.

The nongovernmental organizations recommended that informal production and sales be formalized by making the technology available and placing communities in charge. They stressed, however, that this should not increase the overall supply of alcohol. Their experience is that social movements, in particular women's groups, in developing countries are creative in reducing the supply of alcohol and in reducing the harm due to alcohol.

Other comments

Some participants asked why price and availability had not been on the agenda of the meeting. Nongovernmental organizations and health professionals are involved in promoting implementation of effective policy measures to reduce harm due to alcohol as part of their advocacy work. WHO explained that such policy measures were primarily the responsibility of Member States.

4. Exploring means for more structured and systematic interaction between civil society organizations and the WHO Secretariat at global level

WHO outlined the three main mechanisms for achieving more structured interaction between nongovernmental organizations and health professionals and WHO.

- **Collaborating centres:** An organization that wishes to become a collaborating centre must meet a number of preconditions, such as experience in working with WHO, an agreed work plan, a location, staff and acceptance by the Member State.
- **WHO official status:** Official status allows nongovernmental organizations and health professional organizations to speak at WHO meetings. The organizations present at the meeting that have official status endorsed the importance of this mechanism.
- **Communications platform:** The nongovernmental organizations welcomed the opportunity for strong engagement with WHO at global level. Various possibilities were discussed. The Global Alcohol Policy Alliance offered to act as the contact point and establish an information-sharing network, on the condition that the participants be independent from commercial interests. WHO stated its commitment, as outlined in the resolution, to consult with all stakeholders.

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5. Concluding session

The health professionals and nongovernmental organizations congratulated WHO on the meeting and expressed their gratitude for WHO's efforts to improve the health and reduce the harm due to alcohol of the global population through their public health actions. The Conference of Nongovernmental Organizations in Consultative Relationship with the United Nations announced that their focus next year would be on public health, and alcohol would be included in the discussions. Dr Saraceno thanked all participants for their engagement and contributions during the round-table meeting and said that health professionals and nongovernmental organizations shared WHO's vision of better health for all.

Post script

Following the WHO meeting, the nongovernmental organization sector agreed to set up an information and communication platform in order to facilitate communication between WHO, nongovernmental organizations and health professionals on ways to reduce alcohol-related harm.

The information platform, which will be known as the 'Nongovernmental Organization Alliance for a Global Strategy on Alcohol', will be facilitated by the Global Alcohol Policy Alliance.

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WORLD HEALTH
ORGANIZATION

**WHO ROUND TABLE MEETING WITH REPRESENTATIVES OF
NONGOVERNMENTAL ORGANIZATIONS AND HEALTH PROFESSIONALS
ON WAYS THEY COULD CONTRIBUTE
TO REDUCING HARMFUL USE OF ALCOHOL**

24-25 NOVEMBER 2008

Venue: Salle B - WHO Headquarters, Geneva, Switzerland

SCOPE AND PURPOSE

On 24 May 2008, the 61st session of the World Health Assembly adopted an important resolution on "Strategies to reduce the harmful use of alcohol". The resolution calls for the development by 2010 of a draft global strategy to reduce the harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options. In addition the WHO Secretariat requested to collaborate and consult with Member States, as well as consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol. It is as a part of this latter request that the Secretariat of the World Health Organization is inviting selected representatives of economic operators to a round table meeting in Geneva on 6 November 2008.

The meeting will have a global focus and the major umbrella organizations and professional associations at Global level will be invited. To ensure broad representation, national and regional organizations with an international presence may also be invited from fields where no major global actors have been identified.

The main objective of the round table meeting is to explore the ways in which nongovernmental organizations and professional association can contribute to reducing harmful use of alcohol.

The main focus of the consultation will be on how NGOs and health professionals could contribute to reducing harmful use of alcohol and support the development, implementation and monitoring of strategies and programmes aimed at the reduction of alcohol-related harm. Furthermore, an additional focus will be on exploring possible ways for a more structured interaction at global level between the WHO Secretariat and NGOs.



WORLD HEALTH
ORGANIZATION

**WHO ROUND TABLE MEETING WITH REPRESENTATIVES OF
NONGOVERNMENTAL ORGANIZATIONS AND HEALTH PROFESSIONALS
ON WAYS THEY COULD CONTRIBUTE
TO REDUCING HARMFUL USE OF ALCOHOL**

24-25 NOVEMBER 2008

Venue: Salle B - WHO Headquarters, Geneva, Switzerland

Monday, 24 November 2008

09:00 - 10:00	Registration
10:00 - 11:00	Introduction Opening of the meeting Introduction of participants Welcoming address from WHO Update on implementation of the WHA resolution "Strategies to reduce the harmful use of alcohol" by the WHO Secretariat Discussion
11:00 - 12:00	Statements from the representatives of the organizations and associations Prepared statements limited to 5 minutes per entity Discussion
12:00 - 13:00	Lunch
13:00 - 15:00	Contributions to reduce harmful use of alcohol in selected areas: Advocacy Health sector response Community action to reduce the harmful use of alcohol Drink-driving policies and countermeasures Harm reduction Addressing marketing of alcoholic beverages Reducing the public health impact of illegal and informal alcohol
15:00 - 15:30	Coffee break

15:30 - 17:30 **Contributions to reduce harmful use of alcohol in selected areas (continued)**

17:30 **Closing of Day One**

Tuesday, 25 November 2008

08:30 - 10:30 **Contributions to reduce harmful use of alcohol in selected areas (continued)**

10:30 - 11:00 **Coffee break**

11:00- 12:00 **Contributions to reduce harmful use of alcohol in selected areas (continued)**

12:00 - 13:00 **Lunch**

13:00 - 14:30 **Exploring ways for a more structured and systematic interaction between civil society organizations and the WHO secretariat at the global level.**

14:30 - 15:00 **Conclusions and closing of meeting**



WORLD HEALTH
ORGANIZATION

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ON WAYS THEY COULD CONTRIBUTE
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Al-Anon Family Group

Ms Claire Ricewasser, Associate Director Public Outreach (Professionals)
Ms Marsha Ware, Associate Director International

Alcoholics Anonymous, World Services

Dr Leonard M. Blumenthal, Chair, General Service, Board of Trustees

Alcohol Policy Youth Network

Mr Joao Salviano Carmo, APYN Coordinator

Asia Pacific Alcohol Policy Alliance (APAPA)

Dr Linda Hill, Social Policy Researcher

Canadian Centre on Substance Abuse

Dr Janice Mann, Director, Knowledge Exchange
Dr Florence Kellner, Senior Research Analyst

Eurocare

Ms Mariann Skar, Secretary General
Ms Avalon de Bruijn, Project coordinator, STAP
Mr Claude Riviere, Special Adviser Eurocare, ANPA

Global Alcohol Policy Alliance (GAPA)

Professor David Jernigan, Executive Director, Center on Alcohol Marketing and Youth
Mr Oystein Bakke, Project Manager, Alcohol, Drugs and Development
Mr George Hacker, Director, Alcohol Policies Project, Center for Science in the Public Interest

International Council on Alcohol and Addictions

Mr Rupert Schildböck, Chief Administrative Officer

International Council of Nurses

Dr Tesfamicael Ghebrehwet, Consultant, Nursing and Health Policy

International Federation of Medical Students' Associations (IFMSA)

Mr Guido Maringhidi, Member



International Network on Brief Interventions for Alcohol Problems (INEBRIA)

Professor emeritus Nick Heather, member.

International Society for Addiction Medicine (ISAM)

Professor Tarek A. Gawad, President

IOGT International

Mr Sven-Olov Carlsson, International President

Mr Esbjörn Hörnberg, Executive Director

Lions Clubs International Headquarters

Mr Mike Buscemi, Senior Youth Advisor

Mentor Foundation

Mr Jeff Lee, Executive Director

The Conference of NGOs in Consultative Relationship with the United Nations

Mr Martin Wolf Andersen, Programme Associate

Mr Michael Lane, Junior Fellow

Ms Michelle Pav, Junior Fellow

Worldwide Organization for Women

Ms Afton Beutler, Vice-President, International Affairs

World Association of the Clubs of Alcoholics on Treatment

Dr Ennio Palmesino, Chairman

World Federation for Mental Health

Ms Myrna Lachenal-Merritt, Lead representative of the WFMH to the UN Geneva

World Federation of Public Health Associations

Mr Thomas Vogel, Member, Executive Board

World Medical Association

Dr Otmar Kloiber, Secretary-General

Ms Clarisse Delorme, Advocacy Advisor

World Stroke Organization

Professor Bo Norrving, President

WHO SECRETARIAT

Dr Ala Alwan, Assistant Director-General, Noncommunicable Diseases and Mental Health

Dr Nicolas Clark, Medical Officer, Management of Substance Abuse, Department of Mental Health and Substance Abuse

Dr Ann Hope, Temporary Adviser, Rapporteur

Mr Ted Karpf, Technical Officer, Partnerships and UN Reform

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Dr Margaret Peden, Coordinator, Unintentional Injuries Prevention, Department of Injuries and Violence Prevention

Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse, Department of Mental Health and Substance Abuse of

Mr Dag Rekve, Technical Officer, Management of Substance Abuse, Department of Mental Health and Substance Abuse

Ms Cecilia Rose-Oduyami, Coordinator, Department for Governing Bodies and External Relations

Dr Benedetto Saraceno, Director, Mental Health and Substance Abuse, Noncommunicable Diseases and Mental Health

Dr Maged Younes, Director, Department for Governing Bodies and External Relations



SIXTY-FIRST WORLD HEALTH ASSEMBLY

WHA61.4

Agenda item 11.10

24 May 2008

Strategies to reduce the harmful use of alcohol

The Sixty-first World Health Assembly,

Having considered the report on strategies to reduce the harmful use of alcohol and the further guidance on strategies and policy element options therein;

Reaffirming resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse and WHA57.16 on health promotion and healthy lifestyles;

Recalling resolution WHA58.26 on public-health problems caused by harmful use of alcohol and decision WHA60(10);

Noting the report by the Secretariat presented to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public health problems caused by harmful use of alcohol;¹

Noting the second report of the WHO Expert Committee on Problems Related to Alcohol Consumption² and acknowledging that effective strategies and interventions that target the general population, vulnerable groups, individuals and specific problems are available and should be optimally combined in order to reduce alcohol-related harm;

Mindful that such strategies and interventions must be implemented in a way that takes into account different national, religious and cultural contexts, including national public health problems, needs and priorities, and differences in Member States' resources, capacities and capabilities;

Deeply concerned by the extent of public health problems associated with harmful use of alcohol, including injuries and violence, and possible links to certain communicable diseases, thereby adding to the disease burden, in both developing and developed countries;

Mindful that international cooperation in reducing public-health problems caused by the harmful use of alcohol is intensifying, and of the need to mobilize the necessary support at global and regional levels,

¹ Documents A60/14 and A60/14 Add.1.

² WHO Technical Report Series, No. 944, 2007.

1. URGES Member States:

- (1) to collaborate with the Secretariat in developing a draft global strategy on harmful use of alcohol based on all evidence and best practices, in order to support and complement public health policies in Member States, with special emphasis on an integrated approach to protect at-risk populations, young people and those affected by harmful drinking of others;
- (2) to develop, in interaction with relevant stakeholders, national systems for monitoring alcohol consumption, its health and social consequences and the policy responses, and to report regularly to WHO's regional and global information systems;
- (3) to consider strengthening national responses, as appropriate and where necessary, to public health problems caused by harmful use of alcohol, on the basis of evidence on effectiveness and cost-effectiveness of strategies and interventions to reduce alcohol-related harm generated in different contexts;

2. REQUESTS the Director-General:

- (1) to prepare a draft global strategy to reduce harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options, taking into account different national, religious and cultural contexts, including national public health problems, needs and priorities, and differences in Member States' resources, capacities and capabilities;
- (2) to ensure that the draft global strategy will include a set of proposed measures recommended for States to implement at the national level, taking into account the national circumstances of each country;
- (3) to include full details of ongoing and emerging regional, subregional and national processes as vital contributions to a global strategy;
- (4) to collaborate and consult with Member States, as well as consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol;
- (5) to submit to the Sixty-third World Health Assembly, through the Executive Board, a draft global strategy to reduce harmful use of alcohol.

Eighth plenary meeting, 24 May 2008
A61/VR/8

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Annex 5. Introductory statements

Statement on behalf of Al-Anon Family Groups

Al-Anon Family Groups is a worldwide mutual support group program for anyone affected by another person's drinking. Our program was formed in 1951 and is adapted from Alcoholics Anonymous (A.A.); however, we are a separate entity from A.A. The

Al-Anon Family Group Headquarters, Inc., a non government organization, is located in Virginia Beach, Virginia, U.S.A. While our office primarily serves the United States and Canada, we also provide support services and information to help national or local

Al-Anon offices and to groups forming in any country without an Al-Anon structure. In addition, our office maintains the copyrights to Al-Anon and Alateen literature. Nearly 24,000 Al-Anon groups for adults and 1,775 Alateen groups for teenagers meet worldwide in 133 countries. Our literature is available in 40 languages.

Our organization operates autonomously from other entities and is self-funded by the sale of our literature and contributions from our members. We do not accept grants or monies from non-Al-Anon members or non-Al-Anon related organizations. There are no dues or fees for membership in Al-Anon. Anyone whose life is being or has been affected by someone else's drinking can be a member and attend our meetings. We have no public opinion on issues outside of our program. While we are not allied with any other entity, we do cooperate with them and are available as a resource to other organizations, professionals, individuals, and the media whenever feasible. In essence, we provide public education about the effects of alcoholism upon the family and our community based Al-Anon support groups are open to anyone concerned about someone else's drinking.

We believe that alcoholism, abuse of alcohol, or problem drinking is an illness that affects all who are close to the drinker. Regardless of our relationship to the drinker, we as their relatives or friends experience physical, emotional, and spiritual harms. We use the principles of Al-Anon's Twelve Steps to recover from the impact of the drinking. Whether or not the drinker continues to drink, we use our program's principles to change our own attitudes and to focus on ourselves. We learn from each other's experiences how the application of our program to our daily lives helps us to recover from the impact of someone else's drinking. Through our understanding of alcoholism and alcohol abuse as an illness, we are able to give support and encouragement to the drinker, which in turn reshapes family life. We learn in Al-Anon that we can live purposeful and useful lives whether or not the drinker continues to drink.

The principles of our program are spiritual in nature and applicable to anyone from any type of background. Besides attending our weekly support group meetings, many of our members seek or receive services from professionals. At Al-Anon meetings, members discuss and exchange their experiences as non-professionals without giving each other advice. In learning about alcoholism or problem drinking as an illness affecting the drinker and all who are close to him or her, our members receive valuable information and treatment that aids and supports their recovery. The principles of the Al-Anon program help our members reduce the physical, emotional, and spiritual harms they have encountered from another person's drinking and our members are able to reshape their lives.

We also view recovery as a lifelong process. From hopelessness and despair, the members of Al-Anon Family Groups grow through their application of the Al-Anon's Twelve Steps. A very important aspect of our personal recovery is to help others learn about alcoholism as an illness and how the Al-Anon program can help them.



Statement on behalf of Alcoholics Anonymous

It is a great pleasure to have the opportunity to address this gathering. I would also like to salute the organizers for their initiative in holding this event.

Some might wonder why Alcoholics Anonymous is at a gathering such as this. The fact is, wherever alcohol is consumed, a certain number of individuals overuse the product and develop alcoholism. It is for these alcoholics that we make this program available and accessible.

History

The Preamble of Alcoholics Anonymous, a statement read at the opening of nearly every A.A. meeting in the world, explains pretty well what A.A. is all about:

“Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions. A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.”

Based partly on my decades of involvement with the treatment of alcoholism, I speak to you as a professional in the field. I am also able to share some first-hand experience based on involvement as a nonalcoholic friend of A.A., including my current role as chairman of the General Service Board of Alcoholics Anonymous for the United States and Canada.

The A.A. Fellowship marks June 10, 1935 as the date of its founding. It was on this day that the second member of A.A., Dr. Bob, had his last drink. The other co-founder, Bill W., a stockbroker from New York City, had met with Dr. Bob a month earlier and set off a series of events culminating here today with A.A.s attendance at this WHO roundtable.

In its more than 73 years of growth, we have seen A.A. spread from a small, largely male, middle-class Caucasian group of struggling drunks to a worldwide fellowship of over 100,000 groups with 1.9 million members spread out in about 180 countries. One constant has remained throughout this growth, which is the practice of one alcoholic speaking to another alcoholic and sharing their stories. A.A. recovery is based on the premise that sobriety can be achieved when one alcoholic shares with another their experience, strength and hope in gaining and maintaining sobriety. More importantly, an A.A. member's continued sobriety depends on helping others to recover from alcoholism. This was precisely the situation in which our co-founders found themselves during the dark days of the great economic depression in the United States in the 1930s.

The book, Alcoholics Anonymous, was printed in 1939. It became and remains the vehicle for communicating the recovery program beyond one alcoholic speaking to another face to face.

The Recovery Program – The Twelve Steps

The recovery program that is found in A.A.'s basic text, Alcoholics Anonymous, is outlined in Twelve Steps. These Steps synthesize the actions that the first hundred members took to ensure that they could not only put down the drink, but that they could find a way to live their lives happily and usefully. The Twelve Steps are a practical program of action, which have enabled members of A.A. over the last seven decades to affect the necessary physical, mental and spiritual transformation to enable them to attain a comfortable and continuous sobriety.

The Twelve Steps begin with an acknowledgement and admittance that alcoholics are powerless over alcohol and that their lives have become unmanageable. It is this recognition and acceptance that begin the process of freedom from alcohol addiction for members of A.A. The book Alcoholics Anonymous expands on this sense of powerlessness and makes clear that for the alcoholic it is futile to attempt moderate or controlled drinking. The First Step is the beginning. The remaining Steps lay out a program of vigorous action that enables A.A. members to adjust their lives so that their active addiction to alcohol is arrested.

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A.A. Fellowship – The Twelve Traditions

The Twelve Steps define what we are as a society; the Traditions clarify what we are not. You must understand that the structure of A.A. is very loosely organized and is not a traditional hierarchy. The groups have the final authority but delegate it to the various levels of rotating trusted servants or group officers.

Our General Service Office in New York is one of 60 autonomous and independent offices around the world. We have no authority over the others, but are often looked to for guidance due to the fact that the U.S. and Canadian service structure is the oldest and largest. We always maintain that other local offices and structures in the world may experience different challenges and find different solutions. The determination must be based on their own understanding of the Twelve Traditions of A.A.

The Third Tradition is fundamental to the nature of our Fellowship. It states that we have no requirement for membership other than a desire of alcoholics to do something about their drinking. If you are alcoholic, you are welcome no matter what other problems you may have. It has kept our doors open to women, young people, and people of all races and social classes. We have found that we can deny our solution to no alcoholic.

Tradition Five emphasizes the importance that all the groups stay uniquely focused on carrying the message of recovery from alcoholism. This means that we are not involved in prevention, education, or research. When someone has a desire to address a drinking problem, we are there.

In Tradition Six, it notes that we align ourselves to no one and maintain a gentle, yet strict principle of cooperation and non-affiliation.

Our Seventh Tradition guides us to accept no money from outside sources. We are not in competition with anyone for money. We do not give grants or seek them from anyone.

Tradition Ten guides us not to engage in public controversy, and we have no opinion on matters outside of our Fellowship and the A.A. recovery program. For example, we are not pro or anti-alcohol. This is an issue outside of our area of concern. We simply acknowledge that it is a reality in the world of today.

The principle of anonymity is the foundation for all that we do and is expressed in Traditions Eleven and Twelve. Anonymity offers the new member an assurance of confidentiality as they begin their A.A. experience. Anonymity also ensures us that we do not attempt to depend upon the power of individual personalities in the Fellowship.

Relationship with Professional Community and Treatment

As the treatment of alcoholism matured from the more brutal forms of the early 20th century, many professionals realized that having a support system for sober alcoholics was important. The term we in treatment and medical fields use is “follow-up.”

Of course, follow-up is required in many treatment modules, and more and more professionals encourage their clients/patients to attend A.A. meetings in conjunction with the professional visits.

A.A. meetings are often held in treatment centers and hospitals around the world. In some countries, our entry was through the assistance of members of the medical community. We are gratified by their support and cooperation, and anticipate that we will always have a good and fruitful relationship with these professionals. Our growing membership around the world will always be ready to cooperate with any professional efforts to help the still-suffering alcoholic.

The close cooperation of A.A. and alcoholism treatment programs developed by professions is a winning combination for the alcoholic drinker. The simple fact is that no professional can treat an alcoholic forever. Thus, having a program of mutual support to assume the continuing therapy is essential.

A.A. Around the World

As I mentioned in my introduction, A.A. is found in approximately 180 countries around the world. It was first feared that A.A. would not work in Europe because of its North American roots. This proved untrue. Ireland and the United Kingdom began to have A.A. groups in the

1940s. A.A. began around the same time in Australia and New Zealand. It was also feared that A.A. would not work in other languages, but Norway and Mexico both began to have success with translating the material into their native languages. In Montreal, bilingual native French-speaking members began to translate portions of our literature and started French-language meetings. The Fellowship has developed to where almost 90% of the membership in Quebec is French-speaking.

Some felt that A.A. would not work in non-European cultures, but A.A. has existed in Asia for over 30 years. As has frequently happened, A.A. in Asia began through the work of the professional community and A.A. members who traveled or moved to other lands. A.A. India recently passed the 50-year milestone.

We have A.A. literature available in over 80 languages and our basic text, *Alcoholics Anonymous*, is now available in 57 languages.

Finally, I would like to personally extend to each one of you, an invitation to the 75th anniversary celebration of Alcoholics Anonymous at the 2010 International Convention in San Antonio, Texas, July 1 – 3, 2010. We anticipate an attendance of upwards of 50,000 people, all coming together in celebration and gratitude for Alcoholics Anonymous and the gift of sobriety it has offered to millions.

At the 1965 International Convention, co-founder Bill W. read the following statement and asked the members at the event to join with him in repeating it. The statement reads as follows:

“I am responsible... When anyone, anywhere, reaches out for help, I want the hand of A.A. always to be there. And for that: I am responsible.”

A.A. holds itself true to that commitment, and I will be forever grateful to have been associated with this extraordinary organization. I am pleased to have had the chance today to give you this first-hand explanation of Alcoholics Anonymous. I hope that you consider looking into the possibility of adding Alcoholics Anonymous to the roster of resources you use in treating alcoholism in your various countries. In some instances, you may not realize this resource already exists within your nation's borders. I would be delighted to speak with you and provide you with local contact information. A.A. is always ready to have a cooperative relationship with any professional endeavoring to help the still-suffering alcoholic.

Leonard Blumenthal

Chair, GSB US/Canada

Statement on behalf of Alcohol Policy Youth Network

Dear Representatives of WHO and of NGO's from across the world,

First of all I would like to express my gratitude for the opportunity to be here among you today and share our work, views and ambitions with you at the same time as learning not only what all of you are doing but also how we can complement the work that is being developed on alcohol harm reduction across the globe.

I would also like to stress the importance of meetings such as this and the tremendous need for a Global Alcohol Strategy that brings together Member States, Institutions and Civil Society in order to build synergies, complementarities and solutions to tackle the harm alcohol misuse brings to our world.

APYN – Alcohol Policy Youth Network is an umbrella organization of 27 youth organisations from across Europe (21 National Youth Councils and 6 International Youth NGO's), among which IFMSA here present today as well. It was established in 2008, in Budapest, Hungary, with the purpose of empowering young people to be active and valid players in the definition, advocacy, implementation and evaluation of alcohol policies and programmes across Europe, from the local to the European level.

APYN aims at being a capacity building network for youth organisations and young people alike, namely by providing training courses, advocacy schools, seminars and conferences, by

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developing easily accessible and understandable tools for young people and by transferring to young people the information about alcohol related harm.

APYN does not aim to reproduce existing efforts but to complement them and to facilitate youth involvement in them. With this philosophy in mind since the beginning, APYN has worked closely with a number of partners that are today sitting in this room, such as EUROOCARE or GAPA. For us the development of synergies between us all is of the utmost importance for the sustainability of our work and for an improvement of the efficiency and efficacy of what we do.

At the same time it is clear for us that our work only makes sense if articulated with the work of Intergovernmental institutions like the European Commission or WHO hence why since our foundation we keep in close ties with these bodies looking for ways where we can be an added value to the work being carried out.

This means that APYN can act as a transporter of information, good practice, resources and support from Institutions to young people in the field. Through our activities we empower young individuals to be able to run their projects, take part in ongoing projects, contribute with their views and ideas, collect their peers views and ideas on how to tackle alcohol related harm among young people in the best possible way.

APYN is also capable of delivering in a timely manner a more accurate picture of young people's realities and perceptions towards alcohol making it easier to diagnose the problem and identify the solution, being that young people are always sitting in the driver's seat throughout the whole process.

APYN is operating at the moment at the European level but aims to expand its work across Europe's borders and plans are already being developed to launch a GAPYN – Global Alcohol Policy Youth Network. Our model is already serving as inspiration to young people across the globe and a similar network has already been established in Nigeria (APYNN).

APYN fosters the idea of alcohol related harm as a civic responsibility and approaches it from an active citizenship perspective. As an outcome of this approach we already introduced alcohol related harm as a priority working area to a number of youth organisations across Europe, which is leading to an unprecedented youth led projects development across the region.

In Europe our presence at the Alcohol and Health Forum of the European Commission allows us to communicate youth views to the European policy-makers and also to the national policy-makers at the same time as we create a flow of information back to the youth organisations at the national and local level. This allows them to engage in ongoing processes while coming up with youth projects that are in line with the overall work being carried out by institutions and governments. In many ways APYN also acts as a liaison between the national youth organisation and the national Ministry of Health or with other civil society actors working in the field.

However the work of an NGO, specially a youth platform like APYN, is not easy and follows a path rich in obstacles and dangers.

If APYN hadn't been supported from the beginning by the European Commission, the Alliance House Foundation and ACTIS Norway, if it hadn't had the blessing of EUROOCARE and of the European Youth Forum, and if it hadn't benefited from a positive historic timing it would be for sure a much endangered endeavour.

As we move forward to the future it becomes evident that if a Global Alcohol Policy Youth Network is to be created then it must be nurtured, supported and blessed in similar fashion, and it is clear for us that the role the European Commission plays at the European level has to be taken upon the shoulders of WHO at the global level.

Investing in youth brings always a positive return, and investing in youth platforms, composed of youth organisations, accountable, democratic, structured bottom-up, respecting human rights and freedom, independent of governments, is always a safe investment.

GAPYN can be instrumental in implementing a Global Alcohol Strategy, by reaching young people everywhere and inviting them to join the solution while abandoning the problem.

It is our responsibility to empower young people and prepare them to be the actors shaping their own future, the environment where they live and to be able to have a positive influence on those around them.

The more we invest in young people the more we enable a better world for all.

Statement on behalf of Asia Pacific Alcohol Policy Alliance

The Asia Pacific Policy Alliance is a network of non-government organisations committed to the development of effective alcohol policy in the Asia Pacific region. We work with other organisations to reduce alcohol-related harm worldwide by promoting policies independent of commercial interests. We are a younger sister organisation of the Global Alcohol Policy Alliance and Eurocare.

In some countries in our region, for example, China and Vietnam, there is no non-government sector as such but members there are nevertheless trying to promote the adoption more effective alcohol policies. Our members typically work at the grass roots in community health and development, rather than in ngos specialising in alcohol issues. They report however that they are seeing increasing problems from heavy drinking, especially among young people, and that there has been an increase in alcohol availability and marketing that appears particularly to target the young. In some Asia Pacific countries there is little alcohol policy; in others there are laws and policies on the books that are never enforced. In others, such as New Zealand and Australia, alcohol policies have part of a general move towards pro-market deregulation, despite concerns about alcohol related harms. Yet their policies are often being taken by small neighbouring countries as a model for what they themselves should be implementing.

APAPA welcomes the opportunity to participate in this public hearing because we believe strong and effective national and global strategies are needed to support the work of ngos trying to reduce alcohol related harm, particularly in the emerging markets for alcohol in low and middle income countries. We believe strong leadership by WHO is needed on this important issue.

APAPA strongly supports development of a global alcohol policy strategy, but believe that to be effective in moving our governments to policy action, it will require the status of a Framework Convention.

We look to WHO to set a strong policy direction for member states to adopt, implement and enforce integrated packages of effective policies, especially:

- Taxes affecting price
- Controls on alcohol availability
- Drink-driving laws, and
- Marketing controls, reducing exposure to alcohol promotion messages.

In the Asia Pacific region, the Western Pacific Regional Office's Regional Alcohol Strategy already provides an excellent platform for action for ngos as well as governments.

As well as the specific policies above, APAPA recommends that the Global Alcohol Policy Strategy should recommend the following principles as the best way forward:

- Population based policies are most cost-effective
- A preventative approach should be adopted. This may be particularly needed in countries where there are gaps in local data on drinking patterns or harms
- Working across sectors, at all levels, will increase effectiveness.

This last includes WHO working more closely with the World Trade Organization on the health implications of increased trade in alcohol. At present, trade principles override public health principles. The goals of trade agreements are to increase availability and competition, increase choice of products, and lower prices. These are not appropriate goals in the case of alcohol. Current exemptions processes are extremely difficult to implement and are in any case only temporary measures, as the scope of the agreement must be progressively increased in further rounds of negotiations.

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An exception to the principle of working across sectors relates to the particular role of the alcohol industry. The policy development process needs to be independent of commercial interests.

APAPA has growing concerns about the role of the International Center for Alcohol Policy, which is funded by the 11 largest global alcohol companies. Through its publications and website, it is providing high-profile policy tools and advice, especially to emerging markets for alcohol. It promotes mainly the least effective alcohol policies.

This needs to be countered by WHO with authoritative, easily accessed evidence-based information and policy advice. APAPA recommends that in order to do this a WHO Cabinet Office focused on alcohol be created. The role of this will be to:

- Work with the Collaborating Centres and NGOs networks such as APAPA
- Develop new materials and a user-friendly internet communications strategy
- Work with the WTO and other international agencies.

Statement on behalf of The Canadian Centre on Substance Abuse

The Canadian Centre on Substance Abuse (CCSA), a non-governmental organization, is Canada's national addictions agency. Established by an Act of Parliament in 1988, CCSA provides objective, evidence-based information and advice aimed at reducing the health, social and economic harm associated with substance abuse and addictions.

In 2002 the cost of alcohol-related harm in Canada was estimated to be \$14.6 billion – nearly double the cost related to illicit drugs. The need to address alcohol misuse in Canada has been repeatedly identified as an issue requiring national attention. The activities and efforts of CCSA related to alcohol are guided by the National Alcohol Strategy that was launched in 2007.

The National Alcohol Strategy is a comprehensive, collaborative strategy that provides direction and recommendations to reduce alcohol-related harm and promotes a culture of moderation. It was developed and led by CCSA and its partners, with CCSA continuing to play a lead role in its implementation as well as in the evolution of the Strategy.

While the content of the plan is complex, there are three outstanding characteristics that we emphasize here today:

1. The Strategy is unique because its process of development is unique. The Strategy was created by the *collective* work of governments, professionals, non-governmental agencies, law enforcement/justice, Aboriginal organizations and the alcohol beverage and hospitality industries.
2. The Strategy is unique because the partners involved in its creation are active in its implementation. All of the organizations and institutions involved have the responsibility of following through on specific recommendations of the Strategy.
3. The Strategy is unique because it was built to evolve. It is a process, rather than an entity. As such, the collaboration and the cooperation of the partners will ensure sustained attention to reducing harms from alcohol, as it offers the flexibility necessary to adjust to changing circumstances.

In summary, the National Alcohol Strategy is truly a pan-Canada creation, embracing and engaging all those committed to finding and implementing creative, effective actions to reduce harm from alcohol.

Network based in Europe. The GAPA Board contains representatives from all of the world's inhabited continents.

GAPA welcomes the initiative being taken by the World Health Organization to develop a global strategy to reduce alcohol-related harm. In the words of the European health ministers meeting in Stockholm in 2001, it is critical that such a strategy be developed "independent of commercial interests."

GAPA provides expertise, perspective and experience from the ground in reducing alcohol-related harm around the world. It seeks to counter-balance the powerful lobbying activities of commercial interests in alcohol, putting forward a consistent, evidence-based, public health approach.

In this light, GAPA encourages WHO to consider the following in developing the global strategy:

- 1) As the WHO Commission on the Social Determinants of Health recommended in its recently published final report, WHO should learn from the experience of the Framework Convention on Tobacco Control (FCTC), and should initiate a discussion with Member States on regulatory action for alcohol control. As in the FCTC, such regulatory actions should address alcohol advertising, promotion and sponsorship; taxation; the physical availability of alcohol (including outlet density and hours of sale); minimum purchase ages; and other evidence-based strategies to reduce alcohol-related harm.
- 2) The WHO should also encourage Member States to strengthen their capacity to represent health interests in global trade treaties and at the World Trade Organization. Trade treaties must not be permitted to deprive Member States of their ability to regulate and control alcohol as a commodity. WHO and public health voices must be expressed and heard in trade treaty development and implementation.
- 3) The involvement of youth, particularly in the less wealthy countries, is critical. Around the world, and as part of the epidemiological transition, young people are being exposed to a different range of health risks than before, including greater risk from price and other marketing-based inducements to consume alcohol. Adults bear responsibility for allowing this to happen, and the development of human capacity in youth is of concern to all. Young people's voices must be encouraged and heard to ensure that the global strategy encompasses and responds to their rapidly changing and globally diffusing experience.
- 4) Population-based strategies addressing both supply and demand for alcohol need to be complemented by targeting key groups at risk of alcohol-related harm. Screening and brief intervention as well as provision of treatment to those with alcohol dependence are actions of a humane society and should be part of a comprehensive strategy. Measures protecting third parties as well as drinkers themselves should be part of the strategy, and should include drink driving safety measures relating to BAC limits, random breath testing and licence suspension; and health and safety at work regulations.
- 5) WHO also has an important role in enlisting the support and cooperation of other United Nation institutions by seeking to establish an inter agency working group with ILO, UNESCO, UNDP, FAO, WTO and the World Bank, to ensure that all major global bodies comprehend that alcohol is no ordinary commodity and support implementation of effective policies to reduce harm.
- 6) The strategy needs to address the millennium goals. There is a relation between alcohol and poverty that can have a deleterious impact on sustainable development. As well as the economic consequences there is the fact that alcohol related mortality is often highest among the poor in society. International Development Agencies have an important role to play in raising awareness about the issue and in seeking ways to address the inequalities exacerbated by problems relating to alcohol. It would appear appropriate for WHO to organise a workshop for International Development Agencies to discuss the matter.

For its part, GAPA will seek to create and foster supportive networks at global and regional levels able to disseminate relevant information, provide policy advocacy and to undertake specific tasks such as the monitoring of alcohol marketing. GAPA provides a link between major regional alliances such as EURO CARE, APAPA and IAPA, and is also supporting the

establishment and articulation of youth networks in Europe, Africa and Asia. These networks provide a forum for alcohol policy advocates and seek to bring to the attention of governments and non-governmental agencies the social, economic and health consequences of alcohol consumption and related harm. They build on NGOs' abilities to mobilize community resources, to identify and respond to needs in innovative ways, to work in broad coalition with a range of sectors of society, and to organize and press for effective strategies for reducing alcohol-related harm.

In 1995, the European Conference on Health, Society and Alcohol adopted five ethical principles to guide efforts to reduce alcohol-related harm. These principles recognize the rights of all humans to protection from negative consequences of alcohol consumption, impartial information and education about alcohol use and related harm, a childhood free to the extent possible from alcohol-related harm and the promotion of alcoholic beverages, accessible treatment and care for families and individuals with harmful levels of alcohol consumption, and support for the decision not to consume alcohol. WHO should look to these ethical principles to guide a global strategy as well.

GAPA recognizes that there is no one-policy panacea. What is required from WHO is a list of policy options that have proven validity. From these options policy makers can choose and adapt them to their particular social, economic and political cultures. Given strong leadership from WHO, the task of NGOs will be to mobilize civil society to accept ownership of the problem and help to create the political will necessary to successfully reduce the global burden of disease caused by alcohol.

Statement on behalf of the International Council of Nurses

Nurses represent the largest group of health professionals – over 13 million worldwide - and with the greatest contact with the general public and with patients. Nurses are present in all health facilities and in community settings including schools and workplaces. Harmful use of alcohol is a major determinant of preventable injuries, diseases, disability and death. Nurses are key in preventing harmful use of alcohol. Everyday nurses come face to face with problems caused by harmful use of alcohol including: injuries associated with violence, falls and traffic accidents, family disruption, sexually transmitted infections including HIV due to unsafe practices and foetal alcohol syndrome to name just a few.

It follows then that nurses need to be fully involved in reducing the harmful use of alcohol. Yet this goal remains largely unfulfilled. As the global voice of nurses and nursing that represents 132 National Nurses Associations (NNAs) and millions of nurses worldwide, the International Council of Nurses (ICN) is in a position to mobilise its member associations against harmful use of alcohol.

ICN is also in a position to establish partnership with WHO, other health profession associations, NGOs and others to strengthen the role and contribution of nurses in concerted alcohol control strategies to reduce alcohol-related burden of injuries, disease, disability and death.

Nurses are well positioned to provide cost-effective preventive and therapeutic care. As well nurses have a vital role in screening and detection and implementation of treatment for alcohol-related harm.

Statement on behalf of International Federation of Medical Students' Associations

Honourable Mr Chairperson, Distinguished Delegates and Guests

The International Federation of Medical Students' Associations (IFMSA) is one of the largest student organizations in the world with over one million members in 97 countries worldwide and is recognized as the international voice of medical students around the globe. IFMSA has been in official relations with the WHO since 1969 and is partnered with numerous organizations including UN Agencies and other youth organizations. During the last years within the Federation we have scaled up to the existing need, by cooperating internationally in the foundation of multidisciplinary networks for the prevention of the alcohol related hazard,

organizing lectures and events to raise awareness within medical students and strongly supporting the relevant resolutions, in both the 60th and the 61st World Health Assembly.

People's health and especially young people's health is seriously affected globally by alcohol related harm. That is why we share the belief that our role is double as a Federation of future physicians and as a student organization. There are three levels of intervention that each doctor shall be active in to counteract the global burden of alcohol related hazard. Individually the doctor shall intervene with patients and at-risk drinkers during the daily clinical practice; socially the doctor shall encourage the alcohol control policy advocacy; globally the doctor shall cooperate for the implementation of the Global Strategy that are under development. As a student NGO, our role is not limited in raising awareness or educating our own members, but also cooperating with our partner student organizations aiming to raise efficiently the topic in the relevant political and societal forums.

IFMSA, the international voice of medical students, is here to emphasize the importance of medical students and international NGOs in the fight for the formation and implementation of the Global Strategy. Utilizing our strengths and opportunities the Federation shall work intensely to meet our goals for raising awareness for the alcohol related hazard, advocating for the relevant health policies, educating medical students on how to meet the needs of their triple role as doctors, individually, socially, globally.

Through the Standing Committee on Public Health (SCOPH), the Federation calls public health aware medical students worldwide to unite their voice, by preparing and running campaigns and events, internationally, nationally or locally, to raise awareness on specific public health problems. Alcohol is a major global burden and is being addressed so. Street action activities, public campaigns and awareness activities are being organized, focusing not only on the health problems related to alcohol, but primarily on the social aspect of the problem, violence and injury prevention, road safety and protection of third parties. Such activities draw the attention of international and national media, which can multiply the impact of our actions, when used properly. The decades of international and national publications of the Federation are also a strong tool within the academic circles on a global level.

Advocacy for the alcohol control policy development or reinforcement is also a major field in which the Federation can be effective in. Through our participation in student networks, such as the Informal Forum of International Student Organizations, in special multi-disciplinary networks, such as the Alcohol Policy Youth Network, and through our interventions in international health and political forums, the Federation can be a strong partner for the formation and implementation of the appropriate Global Strategy.

The decades of IFMSA ordinary meetings all year round and a series of alcohol advocacy schools that is about to be launched, are core events to get our members trained and educated on how to treat the problem. In more than ten international meetings and at least one hundred national meetings, medical students can build a strong network of future doctors who will fulfill their triple role concerning the problem. As individuals they will be able to intervene briefly with their patients about alcohol related harm on their daily practice, detect the problem at an early stage and treat the at-risk drinkers properly. As vital members of their society they will advocate effectively for the alcohol control policies and finally globally they will continue participating in international networks of health professionals supporting the Global Strategy.

Today, more than ever, medical students are ready to work as equal partners supporting the formation and implementation of the Global Strategy, responding to the evident need and contributing to meet the needs of time.

Thank you for your attention.

Statement on behalf of International Network on Brief Intervention for Alcohol Problems

INEBRIA is the international network on brief interventions for alcohol problems, with the secretariat based on the Health Department of the Government of Catalonia <http://www.inebria.net/Du14/html/en/Du14/index.html>, and with a South American regional section <http://www.inebrialatina.org/>.

The **aim** of INEBRIA is to promote wide implementation of brief interventions in a variety of settings for hazardous and harmful alcohol consumption at local, national and international levels.

The **objectives** of INEBRIA are:

- 1) To share information, experiences, research findings and expertise in the area of alcohol brief interventions.
- 2) To facilitate training on brief interventions and provide assistance to countries and institutions to adapt and implement brief interventions, particularly with regard to the transfer of knowledge and technology from high income to low income countries
- 3) To promote best practice and develop guidelines for the wide dissemination and implementation of brief interventions.
- 4) To identify gaps and needs for research in the field of alcohol brief interventions, promote international research co-operation and set standards for research in this field.
- 5) To integrate the study of brief interventions with the wider context of measures to prevent and reduce alcohol-related harm.
- 6) To pay particular attention to the needs of young people in relation to alcohol brief interventions.

Given the widespread harm due to excessive alcohol consumption, INEBRIA recognizes the importance of implementing screening and brief intervention (SBI) programmes for individuals with hazardous and harmful alcohol consumption in a wide variety of primary care and other settings.

THE EVIDENCE FOR EFFECTIVENESS OF SBI

- Brief intervention, usually in the form of brief advice taking no more than 5-10 minutes to deliver, heads the list of effective evidence-based treatment and intervention methods for alcohol use disorders and is supported by more research than any other form of intervention in this area.
- There is extensive evidence from a variety of health-care settings in different countries for the effectiveness of early identification and brief advice offered in primary care for persons with hazardous and harmful alcohol use in the absence of severe dependence
- Evidence for effectiveness in other medical settings (eg, accident and emergency departments, general hospital wards) is promising and research on applications in other medical and non-medical settings (eg, criminal justice services, educational establishments, workplaces) is currently underway.
- There is no clear evidence at present that more intensive brief interventions are more effective than brief advice, although this conclusion may change in the light of further research findings.
- SBI is being implemented and evaluated in both high-and low-income countries, with an increasing evidence base for effective implementation strategies.
- The cost-effectiveness of such interventions is in the range of \$2,000-4,000 per DALY saved and brief interventions for hazardous and harmful alcohol consumption are highly cost-effective when compared to other health-care based interventions.

TOWARDS A GLOBAL STRATEGY

- INEBRIA strongly supports the development of a global strategy to reduce the harmful use of alcohol and agrees that this should be based on the implementation of evidence-based environmental policies, such as price and regulations on the availability and marketing of alcohol products, in addition to widespread and routine delivery of SBI to hazardous and harmful drinkers.

- INEBRIA agrees that identification and brief advice programmes are most effective when supported by sound policies and health systems and integrated within a broader preventive strategy.
- Increased taxation and environmental policies are likely to augment the impact of SBI programmes delivered in primary care and other settings.
- INEBRIA notes that, as the main providers of health care, the many millions of health workers worldwide can contribute substantially to reducing and preventing harmful use of alcohol.
- INEBRIA recommends that health care systems should ensure that early identification and brief advice programmes for hazardous and harmful alcohol consumption are widely available for all alcohol users.
- If widely and consistently implemented, SBI would make an enormous impact on public health worldwide.

INEBRIA SUPPORT FOR A GLOBAL STRATEGY

- Through its website and the linked website to the PHEPA project managed by the Health Department of the Government of Catalonia. INEBRIA will continue to make the best evidence for identification and advice programmes readily available. (<http://www.gencat.net/salut/phepa/units/phepa/html/en/Du9/index.html>)
- Based on the PHEPA assessment tool, INEBRIA will develop a tool that can be used worldwide to assess the delivery of early identification and brief advice programmes at the country level.
- INEBRIA will also prepare two simple guidance notes: 1) for practitioners on how to undertake early identification and deliver brief advice, and 2) for health service providers on how to set up and manage early identification and brief advice programmes.

Statement on behalf of International Society for Addiction Medicine

The International Society of Addiction Medicine is very concerned about the increasing consumption rates of alcohol around the world that are accompanied by related harms, which include physical, neuro-cognitive, psychological, social, cultural and financial. These harms occur due to a spectrum of hazardous use, harmful use and alcohol dependence. Increases in consumption in a community as a whole by 50% have been shown to lead to increased alcohol-related harm by 200%. Therefore any strategy to reduce alcohol-related harm in the community necessarily must address the consumption of alcohol and the influences on that.

There is increasing evidence around the world of rising prevalence of underage drinking by males and females, together with binge drinking especially problematic among the youth, where it is “normalized” by peers and/or parents. These behaviours are associated with interpersonal violence, risky sexual behaviour, unwanted pregnancies, trauma, neuro-cognitive impairment and chronic physical disease.

It is essential to have a combination of appropriate public policy, intervention and treatment approaches to prevent the uptake of inappropriate and harmful alcohol consumption; and provide appropriate help for people who have established alcohol use disorders to facilitate recovery. The key approaches supported by ISAM are prevention, treatment, education and research.

The education and research needs to be broad-based to include the public and professionals such that primary and secondary prevention approaches are highlighted by general media campaigns and training programs for all health care providers – physicians, nurses, social workers, psychologists, dentists, pharmacists etc. The association of alcohol use disorders with other addictive behaviours such as gambling needs to be recognized in the context of the broader disease of Addiction that has been defined by ISAM as a primary, chronic disease characterized by impaired control over the use of substance(s) and/or behaviour(s). This definition further recognizes clinical manifestations along the biological, psychological, social and spiritual dimensions. The comorbidity, primary or secondary (complications), with other physical and mental health problems needs to be taken into account to support proper

assessment and intervention services along the lines of outpatient, inpatient, short-term residential, long-term residential, therapeutic community and mutual support programs.

Partnerships that promote corporate responsibility, government and NGO collaboration need to be established and nurtured to ensure that alcohol-related harm is reduced and the related burden on our society is ameliorated as much as possible.

Statement on behalf of IOGT International

How IOGT International can contribute to reduce harmful use of alcohol

It's very important to make the scientific base on alcohol and effective alcohol policy accessible to both the public and the political level.

So far there has been an overwhelming focus on abuse and excessive drinking while the use itself has received little or no attention. There is a scientific support for targeting the population at large simultaneously with addressing abuse and excessive drinking combined with measures to protect vulnerable groups such as young people and pregnant women. Thus a multipronged approach guarantees success.

Public health policy is more effectively implemented if involving civil society. WHO and its member states need to develop methodology and allocate resources for civil society to take its responsibility as mobilisers, implementers and watchdogs.

There is a strong and apparent conflict of interest between public health and alcohol which is illustrated again and again in the sometimes fierce action by the alcohol industry to stop action by local, national or international bodies when trying to address the growing harm alcohol causes. Public health policy including alcohol policy making should be kept free from interference by vested interests as these obstruct rather than facilitate public health oriented policies.

With affiliates and associates in more than 50 countries IOGT International represents a vast NGO constituency, out of which many national branches and local NGOs have submit their views and experiences in this public hearing. IOGT International has a long history of substance prevention as well as substance treatment, first and foremost alcohol. We are therefore grateful for this opportunity to share with the WHO both science, experiences and a pragmatic and practical view on not only how to reduce but above all prevent harm by alcohol.

With the long and comprehensive experience of working with alcohol, with governments and GOs as well as the NGO community mainly in preventing alcohol harm but also with experience from treatment and rehabilitation work to which can be added excellent working relations with scientists within the alcohol research field, IOGT International can offer guidance and training at all levels from policy making to community based mobilization to counter the negative impact of alcohol.

IOGT International arranges conferences and seminars and involves itself in advocacy work at all levels.

IOGT International facilitates contacts over borders and between NGOs as well as between GOs and NGOs.

With the contacts we have with universities and other research institutions we can initiate research cooperation between developed and developing countries as the latter need surveys/studies to learn each its alcohol landscape, drinking patterns, economic dependence, health and social harm etc.

We support networks (GAPA, IAPA, APAPA, EURO CARE etc) to disseminate facts and experiences in how to bring down consumption of alcohol.

IOGT International with its affiliates constitute a broad and deep resource of knowledge and methodology in reducing alcohol harm. There is also a unique commitment to serve which makes NGOs different from other stakeholders. These resources are available and can be catalyzed into mid- and long term projects at all levels if the organisation can find finance.

Our work is evidence based – needs to be as we are challenging extremely strong vested interests – and accordingly credible and non partisan as we are a non profit stakeholder. The

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public health focus is not compromised and our aim to serve beneficiaries in their capacities as individuals, families or communities.

IOGT International

Sven-Olov Carlsson

President

Statement on behalf of Lions Clubs International Headquarters

Lions Clubs International is the largest service organization in the world and represents 1.4 million members in 205 countries worldwide. Founded in 1917, Lions Clubs International and the Lions Clubs International Foundation has represented a beacon of hope, health, and healing to mankind regardless of race, creed, religion, or politics. Lions Clubs International's work in preventable blindness, health, disaster relief, and youth development have been recognized and applauded by numerous groups, including the Financial Times as the "Number 1 NGO for Corporate Partnership and Collaboration", and the charity Navigator for its excellent work and fiscal responsibility and financial health.

In addition to our work related to sight, vision, and blindness, and the world's most disadvantaged citizens, Lions have placed a high priority in partnering with government agencies, NGOs, and other concerned global health organizations to reduce the effects of alcohol use and abuse and the consequences associated with such behavior, including crime, violence, family trauma, and death. As a proud partner with many highly respected partners and collaborators, including the World Health Organization, the U.S. State Department, the Organization of American States (OAS), and the United Nations, we are obviously eager to increase our effectiveness and impact in the critically important issues of alcohol abuse internationally.

Given the magnitude of the problems associated with alcohol disease and the estimated 2 million plus premature deaths globally, it is clearly incumbent on each organization concerned about world health to work in collaboration regarding this issue. Clearly no one agency, government, or NGO can work in isolation to reach any significant portion of the affected population. The dimensions of this issue are far too large and complex to be addressed without strong cooperation and collaboration. Lions Clubs International has established a priority of working internationally in the work of reducing and eliminating the use and abuse of alcohol and drugs. Our commitment has been to support, fund, and equip teachers, parents, administrators and other school leaders with the effective tools and best practices necessary to help students make wiser decisions regarding the harmful effects of drugs and alcohol. Research over the past two decades has tried to determine how alcohol use begins and how it progresses and clearly many factors can add to a person's risk for alcohol abuse and alcoholism, and many factors can reduce their risk. Lions Clubs International is committed to the development of research-based, best practice prevention programs that focus on intervening early in a child's life to strengthen those protective factors before problem behaviors such as alcohol abuse develop.

Lions Clubs International has been successfully involved in primary prevention for many years and has been instrumental in preparing teachers in over 40 countries. We believe that these best practice programs directed at the K through 12 grade levels that are culturally and linguistically adapted represent cutting edge approaches to successful prevention.

Lions Clubs are eager to enhance our effectiveness and reach by working closely with other government and NGO groups represented at this important round table. Research conducted by the Urban Institute and the National Institute on Drug Abuse (NIDA) indicates that the life skills and a social and emotional approach to prevention is extremely effective at providing effective prevention results, as well as supporting academic, social, and emotional learning.

Lions Clubs International is committed to promoting the development of healthy and responsible young people making informed and healthy decisions about the dangers of alcohol and other drugs, including character development and a commitment to service.



Statement on behalf of World Medical Association

The World Medical Associations (WMA) welcomes the opportunity to contribute to WHO consultation on ways of reducing use of alcohol and reiterates its genuine willingness to engage in the fight against the harmful use of alcohol worldwide.

The WMA has a long-standing commitment towards the reduction of the harmful impact of alcohol on health and society. In 2005, the Association adopted a Statement on Reducing the Global Impact of Alcohol on Health and Society, stressing the causal relationships between alcohol consumption and more than 60 types of disease and injury including traffic fatalities. Alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries.

The WMA denounces the fact that, in recent years, some constraints on the production, mass marketing and patterns of consumption of alcohol have been weakened and have resulted in increased availability and accessibility of alcoholic beverages and changes in drinking patterns across the world. This has created a global health problem that urgently requires governmental, citizen, medical and health care intervention.

The WMA believes that population-based approaches affecting the social drinking environment and the availability of alcoholic beverages are more effective than individual approaches (such as education) for preventing alcohol related problems and illness - however not excluding one another. Alcohol policies that affect drinking patterns by limiting access and by discouraging drinking by young people through setting a minimum legal provision age are especially likely to reduce harms. Laws to reduce permitted blood alcohol levels for drivers and to control the number of sales outlets have been effective in lowering alcohol problems.

Through its members active in all the continents at local, regional and national levels, the WMA can be a powerful instrument to develop and coordinate global actions in the medical field to reduce the harmful use of alcohol with the full involvement of physicians.

Highlights of the recommendations of the WMA:

The WMA urges National Medical Associations and all physicians to take the following actions to help reduce the impact of alcohol on health and society:

- 1) To advocate for comprehensive national policies that include measures to educate the public about the dangers of unsafe and unhealthy use of alcohol, including, but not limited to, education programs targeted specifically at youth;
- 2) To promote national policies that follow 'best practices' from the developed countries, which, with appropriate modification, could also be effective in developing nations. These may include setting of a minimum legal age for the provision of alcohol to young people, restricted sales policies, restricting hours or days of sale and the number of sales outlets, or increasing alcohol taxes
- 3) Physicians should also advocate for the restriction of the promotion, advertising and provision of alcohol to youth so that young people can grow up with fewer social pressures or inducements to consume alcohol
- 4) The development of partnerships with other concerned civil society groups in this area should be promoted for example in the workplace, and when driving, or in schools.
- 5) Physicians are urged to screen patients for alcohol use disorders and at-risk drinking, and to provide specialized treatment and rehabilitation for alcohol-dependent individuals and assistance to their families.
- 6) Finally, WMA recommends promoting consideration of a Framework Convention on Alcohol Control similar to that of the WHO Framework Convention on Tobacco Control that took effect in 2005.

November 2008

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Statement on behalf of Worldwide Organisation for Women

The Worldwide Organization for Women congratulates the World Health Organization on their sponsorship of this roundtable discussion with nongovernmental organizations and health professionals on the Harmful Effects of Alcohol. We are most appreciative for this opportunity to speak today as an ECOSOC accredited UN NGO which supports and sponsors programs, which enhance the health and well being of women and children in many countries and cultures around the world through advocacy and education programs.

CHANGING PATTERNS OF DRINKING: Women have traditionally been less likely to drink and to drink less than men. This is changing with MORE women drinking so the patterns of drinking of men and women are converging and this information needs to be included in public health programs. Women who abuse alcohol, or even occasionally drink to excess, face greater risks to their health than their male counterparts.

PHYSICAL CHALLENGES TO VARY BETWEEN MALES AND FEMALES: Females face more brain damage and memory loss than men who drink the same amount of alcohol. Young women admit to drinking to the extent that they wake up the next morning with virtually no memory of events of the night before. Researchers found that binge drinking among women was linked to unsafe sexual practices and high rates of gonorrhea, more than binge drinking men. Also drinking makes young women more vulnerable to sexual assault as well as unsafe and unplanned sex.

Even if women consume the same amount of alcohol as men, women will have a higher blood alcohol concentration in their system. Alcohol can also impair the functions of the hormone-releasing glands. Those women who take hormones and drink alcohol have resulting higher blood levels of estrogen.

HEALTH RISKS TO FEMALES: Some studies show that drinking more than three glasses of wine a day could increase the risk of developing breast cancer. Alcohol poses a great risk of liver disease to women. Some studies found women who drank more than the recommended safe limit greatly increase their risk of coronary heart disease and overall death rates were seven times higher among women than males who drank two or more drinks per day.

Women who drink in excess are less likely to achieve pregnancy and there are serious risk posed to the unborn child when drinking while pregnant. Research suggests that women may be more likely to develop or to show alcohol problems later in life, compared with men.

AWARENESS of HEALTH RISKS: Since women appear to be more vulnerable than men to many adverse consequences of alcohol use and since there are important differences in the way women's bodies react to alcohol compared with men, education programs for women are essential. MOST alarming, so often women do not know there are such serious health risks linked to drinking just by being female so public health programs are vital.

VULNERABILITY OF YOUNG WOMEN IN HIGH RISK DRINKING: One of three American college campuses, more than half of the students engage in high-risk drinking, consuming four to five or more drinks in a row often termed "binge" drinking. Of these college students, ages 18 to 24, drinking contributes to a significant rise in student deaths, injuries, sexual assaults or date rapes each year. (National Institute on Alcohol Abuse and Alcoholism Task Force on college drinking, 2002) These are a significant but rising numbers increasingly involving women students.

Students who abused alcohol during the academic year experienced other serious problems, including missing class, physical injury, arguing with friends and engaging in unprotected sex.

Heavy drinking students are more likely than their inebriated, but less impaired peers to drive after drinking and 74 times more likely to drive after consuming five or more drinks. In response to these alarming statistics university-community coalitions are leading an effort to reduce alcohol abuse among college students.

COMMUNITY INVOLVEMENT IS THE KEY to Building Awareness as well as resource and education programs geared to women's needs at the local level for women of all ages.



Annex 6. Statement on Advocacy

Statement on behalf of Eurocare

Advocacy is important for Eurocare as its overall goal is to: Raise awareness among European, national and regional decision makers of the harms caused by alcohol (social, health and economic burden) ensuring that these are taken into consideration in all relevant EU policy discussions and promote the development and implementation of evidence-based policies aimed at effectively preventing and reducing this burden.

To this aim, Eurocare:

- Fosters cooperation among member organisations
- Monitors all EU policy developments that have an impact on national alcohol policies
- Engages in dialogue with decision makers
- Seeks collaboration with non- governmental organisations sharing Eurocare's concerns
- Carries out advocacy campaigns
- Responds to consultations and developments through letters and position papers
- Facilitates the collection, collation, analysis, dissemination and utilization of data on alcohol consumption and related harm within the EU and other Member States
- Publishes reports on selected topics
- Organizes meetings and conferences to promote and facilitate exchange of information, experience and good practice
- Provides information and analysis through a website and a regular newsletter.

Eurocare believes NGOs with experience in alcohol policy should build networks in order to play a role in developing national and local action and policies, counterbalancing the influences of the commercial interests and to be a constructive partner to governments and international organisations in addressing alcohol related harm. However there is a need for training of the NGO sector at global level.

There is a need for support from the WHO secretariat to NGO capacity building and advocacy within the limits of their office. WHO can give legitimacy to NGOs and enable them to become more influential partners at local and national level balancing the influence of the commercial operators.

Eurocare sees GAPA as the coordinator of supportive networks at global and regional levels that are able to disseminate relevant information, provide policy advocacy and to undertake specific tasks such as the monitoring of alcohol marketing.

Eurocare is committed to support WHO in developing a Global strategy by working in partnership with other relevant NGOs.

Annex 7. Statement on community action to reduce the harmful use of alcohol

Statement on behalf of EUROCARE

Eurocare believes that all countries should, as a minimum, have in place a coherent alcohol harm reduction strategy. A comprehensive alcohol strategy should take into account public health considerations; should be evidence based, and overall cost effective. It should be underpinned by an integrated approach across relevant sectors and government departments and at different levels, (national, regional and local). It should assess the scale of the problem, include both long-term and short-term targets/objectives and a structure for implementation and monitoring, including clear responsibility/accountability as well as a communication strategy. Integrated strategies should consist of a mix of effective interventions ranging from primary prevention to treatment and rehabilitation.

In addition to national and regional alcohol strategies, a global strategy would provide a common framework and knowledge base for all WHO Member States as well as give an opportunity to build sustainable structures for involving NGOs in reducing harmful use of alcohol at all levels. Even if the strategy is applicable at global level and several areas and problems are common, its implementation must be adaptable to the differing national, religious and cultural contexts, as well as diverging public health problems, needs and priorities. Finally, such a strategy on a global scale should seek to take into account discrepancies in resources, capacities and capabilities among different Member States.

Based on existing evidence, Eurocare believes the following areas for interventions should be included in all strategies:

- 1) Reducing the Affordability and Availability of alcohol to protect public health:
 - Price policy and affordability: Using price policies and excise duty tools as legitimate tools to protect public health. Including a system of alcohol taxation where beverages are taxed proportionately to the alcoholic strength. Price policy is particularly effective in curbing harmful drinking among young people and young adults.
 - Restricting availability by regulating the supply and sale of alcohol; this can be achieved through a comprehensive system of licensing, underpinned by public health considerations. This should seek to reduce both the number, location, density of outlets and control the days and hours of opening. This should also seek to restrict availability of alcoholic beverages in supermarkets and general retail stores; the location of outlets; days and hours of opening.
 - Establishing and enforcing a minimum legal purchase age for alcohol.
- 2) Protecting the unborn child, children in families with alcohol problems.
- 3) Restricting or banning alcohol marketing:
 - This should encompass commercial communications, including volume of advertising, with a particular emphasis on new media. Irresponsible sales and promotions of alcoholic beverages such as happy hours should also be tackled. There is a need for consistent compliance with regulatory frameworks governing the whole supply chain from production to sale and covering all forms of marketing.
- 4) Drink-driving:
 - Maximum Blood Alcohol Concentration level (0,5 g/l and 0,2 g/l for young drivers and drivers of public services and heavy goods vehicles), intensive random breath testing, licence suspension, penalties and mandatory treatment programmes.
- 5) Opportunistic screening and brief interventions in a variety of health care settings, ranging from primary health and maternity care.
- 6) Treatment and rehabilitation of individuals with alcohol problems: Timely specialised treatment should be made widely available for individuals with alcohol dependence



Annex 8. Statement on drink-driving policies and countermeasures

Statement on behalf of Eurocare

Maximum Blood Alcohol Concentration level (0,5 g/l and 0,2 g/l for young drivers and drivers of public services and heavy goods vehicles) should be introduced throughout Europe. Eventually, a lower limit of 0,2g/l should be introduced for all drivers.

Unrestricted powers to breath testing, using breathalysers of equivalent and agreed standard, should be implemented throughout Europe.

Common penalties with clarity and swiftness of punishment, with penalties graded depending at least on the BAL level, should be implemented throughout Europe.

Driver education, rehabilitation and treatment schemes, linked to penalties, based on agreed evidence-based guidelines and protocols should be implemented throughout Europe.

Action to reduce drinking and driving should be supported by a Europe wide campaign. However existing designated driver campaigns should be evaluated for their impact in reducing drink driving accidents and fatalities before financing and implementing any new campaigns.

Effective and appropriate training for the hospitality industry and servers of alcohol should be implemented to reduce the risk of drinking and driving.

Comprehensive community-based educational and mobilisation programmes, including urban planning and public transport initiatives should be implemented to reduce drinking and driving, including alcohol awareness training in all driver instructor training courses.

Resources should be made available to ensure the widespread availability and accessibility of identification and advice programmes to reduce drinking and driving in accidents and emergency departments.

For more information see: *Reducing Drinking and Driving in Europe, Recommendations & Conclusions*, Deutsche Hauptstelle für Suchtfragen (DHS 2008) (European Commission Grant agreement 2005321).



Annex 9. Statements on marketing of alcoholic beverages

Statement on behalf of Eurocare

Eurocare believes in restricting or banning alcohol marketing. This should encompass commercial communications, including volume of advertising, with a particular emphasis on new media. Irresponsible sales and promotions of alcoholic beverages such as happy hours should also be tackled. There is a need for consistent compliance with regulatory frameworks governing the whole supply chain from production to sale and covering all forms of marketing.

STAP – the National Foundation for Alcohol Prevention in the Netherlands (a Eurocare member) promotes a (Total)ban on alcohol advertising. See their attached statement below.

Several longitudinal studies have shown that exposure to alcohol advertising and/or marketing lowers the age of onset of drinking in young people and also increases alcohol consumption on the long term (e.g. Collinsetal.,2007; Ellicksonetal., 2005; Henriksenetal., 2008; Snyderetal., 2006; Stacyetal.,2004). Only one out of 13 longitudinal studies found no effect of exposure to (outdoor) alcohol advertising on drinking behavior (Paschetal.,2007). Expectancies about alcohol already develop long before the onset of drinking. The way alcohol is portrayed in the media contributes to these expectancies.

To better protect children against the effects of alcohol marketing, STAP pleads for a total ban on alcohol advertising (similar as with tobacco). In case a total ban for all alcohol advertising is not feasible, then at least a restriction of the volume of alcohol advertising/marketing for traditional media (e.g. radio, tv, print, outdoor) is suggested (e.g. time ban for radio and television). For relatively new types of media (e.g. internet, buzz marketing, viral marketing, sponsoring, SMS, etc) a total ban is preferable since these types of alcohol marketing cannot be easily monitored by independent parties. This way, it will never be clear how many Minors are being reached by this type of advertising. The industry has more access to this type of data, but these data are not accessible for the public.

The voluntary codes of the industry focus mainly on content restrictions of alcohol advertising and to a far lesser extent on restrictions of the volume of alcohol advertising (STAP, 2007). We know from research that the volume of alcohol advertising has a large impact on drinking behavior of young people (e.g. Collins et al., 2007; Ellickson et al., 2005 ; Henriksen et al., 2008; Snyder et al., 2006; Stacy et al., 2004).

In the self regulation codes, the industry often employs the so-called 25%-rule. The EFRD (European Forum for Responsible Drinking) even uses a 30% rule. According to this rule, no audience consisting of more than 25% (or 30%) minors may be reached with alcohol advertising. However, EU27 Member States contain on average 19,4% minors (Eurostat). In practice, alcohol advertising can therefore take place freely because the 25% limit (and to an even lesser extent the 30% limit) will not be crossed easily. Another disadvantage of this rule is that in absolute numbers, still a lot of minors are being reached by alcohol advertising. In theory 100 % of the EU minors are allowed to be reached by alcohol advertising, as long as there are more adults watching (e.g. with soccer cups).

EUROCARE attaches the full statement from the National Foundation for Alcohol Prevention in the Netherlands (STAP).

Statement on alcohol marketing by STAP (initiator of EUCAM)

November 2008

STAP (the Foundation for Alcohol Prevention in the Netherlands) is a national, independent non-profit organisation that advocates effective alcohol control policies and works towards public awareness of the risks of alcohol. STAP is a member of Eurocare, the European Alcohol Policy Alliance. STAP has been monitoring the alcohol marketing in the Netherlands for several years (commissioned by the Dutch Ministry of Health, Welfare and Sports). Consequently, we have gained a lot of knowledge about the functioning of alcohol marketing regulations. STAP has initiated EUCAM (the European Centre for Monitoring Alcohol Marketing) in which dissemination of impact research on the effects of alcohol marketing is supported and systematic monitoring of alcohol marketing stimulated. EUCAM has a large network of

researchers, representatives of NGOs and policymakers who are informed on developments in alcohol marketing. EUCAM contact persons in more than 15 European countries are active in disseminating news on alcohol marketing (regulations). From 2009, systematic monitoring of alcohol marketing will be implemented in five European countries (supported by the AMMIE project, co-funded by the European Commission).

We would like to thank the WHO for the opportunity to share our views and experiences about alcohol marketing regulations.

Need for alcohol marketing regulation.

Longitudinal studies consistently show a modest but significant effect of exposure to alcohol marketing on adolescents' alcohol consumption. Adolescents who are exposed to a higher volume of alcohol marketing are more likely to start drinking alcohol earlier, to drink more frequently and to drink higher amounts of alcohol during one occasion. Exposure to alcohol marketing practices that are perceived as attractive by youngsters increase the effect of exposure to alcohol marketing on drinking behaviour.

The first step is to reduce youth exposure to alcohol advertisements that young people perceive as attractive. Alcohol beverage marketers often claim to target young adults (e.g. age 18-24). Minors look up to this age group and are attracted to similar elements and themes in alcohol advertisements. Attractive elements are for example: the use of celebrities, popular music and humour. To protect young people against attractive advertisements, these themes should be restricted in alcohol marketing regulations.

More importantly, alcohol marketing regulations should be focused on the restriction of the volume of alcohol marketing.

Restrictions of the volume of alcohol marketing to which young people are exposed can have different forms and can be implemented in various degrees. Although partly bans (for example a time ban on TV) can decrease the total volume of alcohol marketing practices, substitution effects are a large problem: if broadcasting advertising is restricted, a shift to other types of marketing is expected. For this reason, and because of the difficulty of monitoring the audiences reached by less traditional alcohol marketing tools, a total ban of alcohol marketing is preferred.

Alcohol marketing regulations should address not only alcohol advertising in traditional media, but also alcohol advertising and promotion by non-traditional tools. Longitudinal studies show for example that exposure to promotional merchandise of alcohol brands has a relatively large impact on drinking behaviour of youth compared to the effect of exposure to alcohol marketing in more traditional media. Although challenging, marketing forms as viral marketing, event sponsoring, product placement and price marketing need to be addressed in alcohol marketing regulations and monitoring of alcohol marketing. The cumulative effect of alcohol marketing exposure emphasizes the importance of a comprehensive alcohol marketing regulation.

Statutory regulations should be emphasized, since there is increasing evidence that self-regulation is unable to protect young people effectively against harmful effects of exposure to alcohol marketing. The intense competition among alcohol producers propels the expansion of alcohol promotion and advertising. There is strong resistance on the part of the industry to further control the volume of alcohol advertising and promotion (Giesbrecht 2000). Due to the conflict of interests, we should not ask the alcohol industry to restrict the volume of alcohol marketing themselves. The volume of alcohol marketing should be restricted in statutory regulations.

Scientific literature shows that self-regulation tends to be fragile and largely ineffective in countries where it is the primary way to control alcohol advertising, in part because it is often circumvented and rarely enforced.

STAP is a strong proponent to a world wide Framework for Alcohol Policy similar to the WHO Framework on Tobacco Control. This is especially important to restrict the harmful effects of alcohol marketing. Alcoholic beverages tend to be marketed globally. At this moment legislation on alcohol marketing, however, is often structured at the national or regional level and is not able to regulate international strategies of alcohol marketing. This emphasizes the

tobacco control field the evidence was also clear that full bans would be the most effective public health strategy, the Framework Convention itself recognizes that full bans are not feasible in every national situation, and offers a “floor” for national action in this area. This floor includes prohibiting all forms of advertising, promotion and sponsorship that are in any way false, misleading or deceptive, or create erroneous impressions about product characteristics, health effects and hazards; requiring health warnings on advertising, promotions and sponsorships; requiring disclosure to relevant authorities of expenditures on non-prohibited marketing activities; and adopting restrictions on marketing as possible under Constitutional principles where comprehensive bans are not possible.

WHO needs to provide global leadership on what is a global problem. Marketing innovations diffuse globally more rapidly than public health expertise. The President of UB Group Spirits Division in 2004 stated: “The entire Indian map is changing. There has been a huge explosion of disposable income among the young; moreover social drinking has increased. And today users are looking for products that are aligned with global trends; the demand for new age flavours is increasing. The Indian market is ready for alcohol beverages with exotic fruit flavors.” As the alcohol trade continues to become more global, it requires a global public health response. Wealthy countries with more developed public health infrastructures prohibit a variety of marketing practices that are used with impunity in the less well-resourced countries. In the short term, global monitoring and reporting needs to support national regulation of alcohol marketing activities.

GAPA stands ready to assist the WHO in implementing the portion of the strategy relating to alcohol marketing. GAPA members have played leading roles in developing, researching and evaluating a wide range of public health approaches to alcohol marketing in Member States. GAPA members are also engaged in monitoring alcohol advertising, and in raising public awareness about alcohol marketing and its effects. Finally, GAPA believes that the significant role of alcohol marketing in promoting drinking, particularly among youth, provides strong evidence for the need for the global strategy to reduce alcohol-related harm to be developed independent of commercial interests.

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Annex 10. Statements on harm reduction

Statement on behalf of Eurocare

Harm reduction – from a global perspective.

Eurocare believes that a long-term objective should be to provide support and increased awareness worldwide of the wide ranging impact of harmful alcohol use on health, social development, crime and injuries etc.

All WHO Member States should develop and adopt their own comprehensive national alcohol strategies/policies. A majority of WHO Member States are currently lacking knowledge of the extent of alcohol related harm, as well as the means, tools and overall capacity to both prevent this harm and treat individuals with alcohol related problems.

Furthermore, there are cross-border issues that require global action to support WHO Member States. Marketing, commercial communication, sales and smuggling of alcoholic beverages have emerged as worldwide concerns, which need to be addressed by an overarching global framework for action.

Further, a cross national and international approach, would allow the establishment of mechanisms for sharing country experiences and exchanging good practices.

One central task for the WHO will be to provide the knowledge base for WHO Member State actions, through the development of a global monitoring and information system. Given its international role and profile, sustained global action of the WHO in the field of alcohol related harm, will provide the impetus for local, national, and international action in this field.

The WHO at both regional and global levels will have a key role to play in evaluating the progress made at global level.

Eurocare believes there is a need to embark on specific work on the topic areas:

- Commercial communications.
- Affordability and availability.
- Social welfare and development.
- Prevention of alcohol-related accidents and injuries.
- Prevention of alcohol-related communicable diseases.
- Managing illicit and smuggled alcohol.
- Brief interventions.

Areas in which the WHO can take the lead include;

- Strengthening evidence base at global level and adequate data collection.
- Carrying out repeated and comparative surveys .
- Further developing Global Burden of Disease study.
- Support further research on reducing alcohol related-harm, alcohol's role in spreading of infectious diseases and its role in hindering social and economic development.



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