

THE GLOBE

Global development of
alcohol policies



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THE GLOBE

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Personal reflection on World Health Assembly

Derek Rutherford

WHO boldly states that its mission “shall be the attainment by all peoples of the highest possible level of health” so it was somewhat surprising to hear a delegate on leaving this year’s World Health Assembly remark “I thought I had been attending a World Trade Assembly not the World Health Assembly.” If that delegate had sat with lobbyists of the drinks industry packing the public gallery, where the committee deliberating on a need for a global strategy to reduce alcohol related harm was holding its drafting meeting, it would have confirmed the impression that one had come to a trade and not a health meeting.

Yet it may be rather unfair to damn the majority because of the actions of a minority.

After the first morning’s deliberations of the committee, the drinks industry lobbyists were expressing their dismay and concern. They had good reason to be worried since member state after member state expressed its concern over the growing problems associated with the increased use of alcohol.

From the continents of Africa and Asia came strong support for the resolution, proposed by 40 countries, to further develop a global strategy on the problems caused by the use of alcohol. Despite the heavy burden of communicable diseases faced by Africa, their delegations showed that they did not wish to have to cope with the added burden of non-communicable diseases that would result from the rising tide of alcohol

consumption. They recognised the need for appropriate prevention strategies. Despite this the whole process became stalled in committee since WHO decisions are based on consensus. Finally what emerged was a simple resolution that ‘strategies to reduce the harmful use of alcohol’ and related documents discussed at the Assembly should be included in the agenda of the Executive Board at its 122nd session to be held in January 2008 and requested the Director General, in the interim, to continue her work on this matter.

In this edition of The Globe we publish the Secretariat’s report (page 5); the WHO Global Assessment of public health problems caused by the harmful use of alcohol for 2002 (page 8); and the WHO Expert Committee Report (page 10).

This latter report had only been published on the web in English a few weeks before

the Assembly. This caused some consternation for the US delegation since procedural rules had not been observed. It ought to have been circulated to all delegations in the WHO official languages.

Unfortunately the proposers of the resolution had included it in their preamble. They thought it would lend added weight to their proposals. However, they should have been aware that the expert committee's recommendations would certainly give great concern to the drinks industry and to some member states.

The reaction of Cuba to the resolution was uncompromising for reasons which are difficult to understand. Their reaction was puzzling since in the Pan American Conference on Alcohol Policy in Brasilia in 2005 the Cubans appeared very supportive of public health measures in relation to alcohol. Did national pride and trade get in the way?

Prior to the WHA debate the Swedish Foreign Minister had criticised the human rights record of the Cuban Government. There were those who considered the spat to be the reason for the intransigence of the Cubans towards what they considered to be a Swedish resolution. We cannot believe that this was the motivation lying behind the Cuban position. More likely they were playing to the strong delegation of the drinks industry from their part of the world.

The issue of trade was probably the factor that dominated their actions. Previous WHO decisions on nutrition and the tobacco framework are considered by them as unhelpful to their sugar and tobacco industries. Any move on alcohol is seen as another economic threat. A Cuban foreign office official remarked *"the industry is important to Cuba. It's the fifth largest income earner after tourism and nickel. The alcohol industry gives work and contributes to economic growth."* Reporting on the debate, a Swedish newspaper described it as ending in a 'fiasco'.

Should it be seen in that light? From the outset there could have been simply a resolution that noted the secretariat's report and encouraged further work (which we finally landed up with). However, there was value in opening up the wider debate since vital lessons are to be learnt by the WHO secretariat, member states and nongovernmental advocacy groups.

Apart from a few member states there was overwhelming support for positive action from both developed and developing countries. It is the few that

can block progress. We must recognise the power of entrenched vested interest. The powerful leverage of the drinks industry over politicians and governments particularly in their trade and finance ministries is insidious. In her opening speech to the Assembly the Director General did with great emphasis remark that there was no place for the tobacco industry in the councils of WHO. Whilst we recognise that the drinks industry should be consulted on the implementation of policy, we must emphasise that they have no place at the decision making table. The trouble is the industry wants to have two bites of the cherry – seats not only at trade and industry but also at health. Public Health advocates at member state and international level must have confidence that the governmental health sector should not have to bow to the pressure of commercial profit in setting out and defending evidence based public health strategies to reduce the harms from the use of alcohol. It is up to member states governments to determine the balance between health and trade policies. However we would naturally proffer the advice of Disraeli, a distinguished 19th century British Prime Minister: *"The first priority of any government is the health of its people."*

The WHA debate revealed the minefield there is in finding consensus. Very carefully thought out presentational skills will be needed in writing the future strategy. Member states will need to perceive and understand that they are not being given a take it or leave it 'blue-print' but an array of policy options from which they can adopt evidence based strategies appropriate to their particular political, social and economic cultures in order to reduce and prevent alcohol related harm.

World Health Assembly 2007



Dr Chan
Director General of the WHO

Preliminary reports on the activities of WHO officials to implement the resolution on public health problems caused by the harmful use of alcohol were on the agenda for this year's Health Assembly.

The Secretariat had issued the following report for consideration by delegates:

Report by the Secretariat

Resolution WHA58.26, on public-health problems caused by harmful use of alcohol, requested the Director-General, inter alia, to report to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public-health problems caused by harmful use of alcohol. The resolution also requested, without giving a time limit, the Director-General to draw up recommendations for effective policies and interventions to reduce alcohol-related harm.

The relationships between alcohol consumption and health and social outcomes are complex and multidimensional. A global perspective on public-health problems caused by harmful use of alcohol needs to take into account the many different characteristics, effects and consequences of its consumption on individuals, societies and cultures, and the fact that the health and social consequences can be severe. From a public-health perspective, the message is clear: efforts must be directed towards culturally appropriate and cost-effective interventions that reduce harmful use of alcohol.

Public-health concepts and general theories of vulnerability apply to harmful use of alcohol, and various risk and protective factors have been identified. Even though many people either abstain or drink alcohol in a way that carries low risk for harm,

much alcohol is drunk either in high-risk situations or on heavy-drinking occasions, or both. The interaction between all these individual and social factors implies the need for comprehensive policy measures to reduce alcohol-related harm, not just for the drinkers but also to protect those individuals and groups who are at risk of being negatively affected by others' drinking.

A considerable body of evidence shows not only that alcohol policies and interventions targeted at vulnerable populations can prevent alcohol-related harm but that policies targeted at the population at large can have a protective effect on vulnerable populations and reduce the overall level of alcohol problems. Thus, both population-based strategies and interventions, and those targeting particular groups such as young people, women and indigenous peoples, are indicated. Nevertheless, despite the strong evidence of effectiveness and cost-effectiveness of population-based policies, in some countries support for population approaches has declined in favour of targeted interventions.

Policies and programmes based on substantive evidence should use an appropriate combination of the following strategies: regulating the marketing of alcoholic beverages, (in particular those practices that influence younger people); regulating and restricting their availability; enactment of appropriate drink-driving policies; reducing the demand for alcohol through taxation and pricing mechanisms; raising awareness and support for policies; providing easily accessible and affordable treatment services for people with alcohol-use disorders; and implementing screening programmes and brief interventions against hazardous and harmful use of alcohol.

Regulating the availability of alcoholic beverages through restricted times of sale and reducing the demand for alcohol through taxation and pricing are two of the most cost-effective strategies for countries and communities to reduce or prevent alcohol-related harm.

Among the most successful targeted interventions are deterrence-based policies directed at drink-driving and at violence in places where alcohol is drunk. The imposition of blood alcohol concentration limits for drivers, strongly enforced through highly-visible sobriety checkpoints and random breath-testing by police, can have a sustained effect on drink-driving and reduce the associated crashes, injuries and deaths. Improved management practice within drinking venues can reduce levels of violence on those premises.

Community-based actions and risk-reduction measures that focus on the drinking context are among the strategies and interventions that need to be further explored and tested. Community actions to deal with alcohol-related problems are of particular importance in settings where consumption of alcohol produced informally or illegally is high, where social consequences like public drunkenness, maltreatment of children, violence against intimate partners and sexual violence are common.

Regulating access to alcohol through restrictions on purchasing age is a particularly effective strategy for preventing alcohol-related health and social problems, such as violence, among young people. Another effective strategy for reducing drinking among young people is to regulate the marketing of alcoholic beverages, including a ban on advertising practices that influence young people.

Extensive evaluation of the provision of treatment services for people with alcohol-use disorders has demonstrated the effectiveness of various approaches, including behavioural change strategies, pharmacological interventions and mutual support groups. In addition to new mechanisms for the organization and financing of treatment services, advances have also been made in a variety of settings, including primary health care, in the early identification and management of hazardous and harmful drinking.

Access to affordable, non-judgemental and effective treatment for people with drinking-related disorders is an important component of societal and community responses to alcohol-related problems. Ensuring that access requires adequate treatment policies that include delivery and integration of prevention and treatment services at different levels. The effects of particular measures will depend on local circumstances. Given the variations in average levels of alcohol consumption, drinking patterns and drinking contexts between and within countries, alcohol-policy priorities at different levels should be informed both by relevant epidemiological evidence and research findings on effective prevention strategies and interventions.

Effective national or local policies can gain from an appropriate assessment of the context for which the policy is formulated, in terms of drinking patterns, problems and societal responses to the problems. Monitoring, surveillance and evaluation should be integral parts of a more comprehensive alcohol policy framework.

Monitoring alcohol consumption, related harm, policy responses and progress made towards reducing harmful use of alcohol at different levels requires cooperation among competent national and international organizations and other bodies. Effective regional and global information systems require international collaboration on monitoring and surveillance activities, and further development of guidelines and procedures for the collection, analysis and dissemination of alcohol-related data.

Policies to reduce harmful use of alcohol reach far beyond the realm of health and involve such sectors as development, fiscal policy, trade, agriculture, education and employment, thus falling within the responsibilities of numerous governmental agencies and organizations. An appropriate coordination mechanism is therefore important for any comprehensive alcohol policy. Combating the production, sale and consumption of illicit alcohol is one example of an issue that needs concrete action by many stakeholders at different levels.

Traditionally, most alcoholic beverages were consumed in the country of their production, and alcohol policies were implemented within country jurisdictions. Until recently, government controls of the alcohol market have been either country-based or, in federal countries, locally-based, with responsibility for health and social systems responses to alcohol problems often resting with municipalities. In recent decades, this situation has in many ways been transformed. Alcohol production and trade are part of the global economy with rapid dissemination of new products and the development of new markets.

Greatly increased trade and travel have provided many more opportunities for the transfer of alcoholic beverages across country borders, whether as legal imports or as smuggled goods. Other international aspects of alcohol production and distribution have assumed large proportions, in terms of rapid consolidation of multinational producers, international licensing and co-production arrangements, and multinational advertising agencies which promote alcoholic products. All these factors suggest that, increasingly, alcohol-related problems cannot be dealt with by countries in isolation.

Evidence-based strategies to reduce alcohol-related harm have been extensively discussed in all WHO regions. Regional committees have adopted resolutions on the subject, including a regional strategy, and the Regional Committee for South-East

Asia endorsed policy options for control of alcohol consumption as a minimum framework for the Region. In the extensive consultation process at the global level the Secretariat has focused so far on the analysis of the different viewpoints among a wide range of stakeholders on major issues raised in resolution WHA58.26. The Executive Board at its 120th session noted the progress made in implementing resolution WHA58.26.ⁱⁱ

Global leadership and advice on how to shape and sustain effective responses to public-health problems caused by harmful use of alcohol are urgently needed, particularly in countries with rapidly deteriorating trends and patterns of alcohol consumption and alcohol-related harm and a background of increasing availability and affordability of alcohol. They are also needed in countries where implementation of culturally-appropriate and cost-effective control measures has been or is in danger of being undermined. The alcohol-related disease burden could be considerably alleviated by paying greater attention to prevention and treatment, and more generally, public health-oriented policies on alcohol. The Secretariat's work so far provides the basis for recommendations for effective policies and interventions in order to reduce alcohol-related harm, and further consultations are needed.

The report was supported by a global assessment of public health problems caused by the harmful use of alcohol for 2002.

References

- i See document *A60/14 Add.1* for an assessment of public-health problems caused by harmful use of alcohol.
- ii See document *EB119/2006-EB120/2007/REC/*, summary record of the thirteenth meeting of the 120th session, section 2.

WHO Global assessment of public-health problems caused by harmful use of alcohol for 2002

Alcohol is ranked as the fifth leading risk factor for premature death and disability causing considerable public-health problems.

Estimates for 2002 show that at least 2.3 million people died worldwide of alcohol-related causes accounting for 3.7% of global mortality. Alcohol consumption was responsible for 4.4% of the global burden of disease (see Table 1).

The impact of alcohol consumption is greater in younger age groups of both sexes - 3.7% of all deaths in all age groups (6.1% in men, 1.1%

in women) and 5% of deaths under the age of 60 (7.5% in men, 1.7% in women). Fatal injuries occur relatively early in life.

Harmful use of alcohol is the third leading contributor to disease burden in developed countries, the first for men in developing countries in which mortality rates are low, and eleventh in developing countries with high mortality rates.

Neuropsychiatric disorders, mainly from alcohol use and including alcohol dependence, account for more than a third (34%) of the burden of disease and disability attributable to alcohol, followed by unintentional injuries like road traffic crashes, burns, drowning and falls (altogether 26%), intentional injuries including suicide (11%), cirrhosis of the liver (10%), cardiovascular diseases (10%) and cancer (9%) (see Table 2). When only alcohol-related deaths are considered, unintentional injuries

(25%), cardiovascular diseases (22%) and cancer (20%) are the three biggest categories.

The disease burden estimates reflect the harm attributable to alcohol after the protective effects of alcohol, particularly for ischaemic heart disease, have been taken into consideration. Any threshold for harmful use of alcohol is difficult to define even though evidence suggests that low or moderate alcohol consumption can reduce mortality and morbidity in a

Region	Deaths ^a		Years of life lost ^a		Number of disability-adjusted life-years lost ^a	
	Number of deaths (thousands)	Percentage of all deaths	Number (thousands)	Percentage of all years of life lost	Number (thousands)	Percentage of all disability-adjusted life-years lost
Global	2,123	3.7	38,177	4.1	64,975	4.4
Men	1,836	6.1	32,553	6.6	54,970	7.1
Women	287	1.1	5,625	1.3	10,006	1.4
African						
Men	184	3.4	4,165	3.0	5,757	3.2
Women	50	1.0	1,050	0.8	1,429	0.8
The Americas						
Men	277	8.7	5,616	14.1	12,026	15.2
Women	46	1.7	871	3.2	2,569	3.9
SE Asia						
Men	285	3.7	5,314	3.8	8,088	3.8
Women	28	0.4	586	0.5	867	0.4
European						
Men	532	10.8	9,085	17.8	14,017	16.7
Women	77	1.7	1,644	5.2	2,553	3.8
East Mediterranean						
Men	20	0.9	394	0.9	480	0.7
Women	3	0.2	57	0.1	77	0.1
Western Pacific						
Men	539	8.5	7,979	10.1	14,603	10.3
Women	82	1.5	1,417	2.3	2,511	2.1

Table 1. Global and regional burden of disease attributable to alcohol consumption, 2002

^a Adjusted for beneficial effects attributable to alcohol consumption.

Disease category	Total for			Total for		
	Men (number)	Women (number)	Men and Women (number)	Men (%)	Women (%)	Men and Women (%)
Maternal and perinatal conditions (low birth weight)	52	42	94	0.1	0.4	0.1
Cancer	4,593	1,460	6,054	8.2	12.9	9.0
Diabetes mellitus	0	20	20	0.0	0.2	0.0
Neuropsychiatric disorders	19,393	3,722	23,115	34.6	32.9	34.3
Cardiovascular diseases	5,711	887	6,598	10.2	7.8	9.8
Cirrhosis of the liver	5,415	1,468	6,883	9.7	13.0	10.2
Unintentional injuries	14,499	2,647	17,146	25.9	23.4	25.5
Intentional injuries	6,366	1,051	7,417	11.4	9.3	11.0
Total "detrimental effects" attributable to alcohol	56,029	11,297	67,326	100.1	99.9	99.9
Diabetes mellitus	-225	-86	-312	21.3	6.7	13.3
Cardiovascular diseases	-834	-1,205	-2,039	78.7	93.3	86.7
Total "beneficial effects" attributable to alcohol	-1,059	-1,291	-2,351	100.0	100.0	100.0
All alcohol-attributable net disability-adjusted life-years lost	54,970	10,006	64,975	100.0	100.0	100.0
Total disability-adjusted life-years lost due to all causes	772,912	717,213	1,490,126			
Percentage of all disability-adjusted life-years lost attributable to alcohol	7.1%	1.4%	4.4%			

Table 2. Disability-adjusted life-years lost attributable to alcohol consumption in the world, 2002

few diseases and for certain age groups. For many diseases, such as breast cancer, the risk increases with the amount of alcohol drunk, with no evidence of a threshold effect.

The global economic cost of the harmful use of alcohol in 2002 (Cost in US\$)

This has been estimated to be between 210,000 million and 665,000 million:

- Illness 50,000–120,000
- Premature mortality 55,000–210,000 million
- Drink-driving 30,000–55,000 million
- Absenteeism 30,000–65,000 million
- Unemployment 80,000 million
- Criminal justice 30,000–85,000 million
- Criminal damage 15,000–50,000 million

The total equates to between 0.6% and 2.0% of global gross domestic product.

The WHO assessment cautions that “due to current trends both in availability of alcohol and increases in alcohol consumption the detrimental impact of alcohol is expected to increase in the future if further interventions are not introduced.”

WHO Expert Committee Report

The expert group emphasised the fact that their recommendations were built on an evidence base of alcohol policies which is globally relevant. Their recommendations included among other things that WHO:

- should continue to play a leading role in continuing a global response to the global nature of alcohol problems
- liaise with inter-governmental agencies at regional level, to seek inclusion of alcohol policies in relevant social and development agendas
- support governmental bodies at national and sub-national levels and in particular to low and middle-income countries to give high priority to the prevention of the harmful use of alcohol; to formulate, develop and implement adequately financed action plans on alcohol and implement and evaluate evidence-based policies.

In recognising the role that non-governmental organizations can play in supporting alcohol policy, the Committee recommended that WHO should

strengthen its processes of consultation and collaboration with non-governmental organizations that are free of a potential conflict of interest with the public health interest.

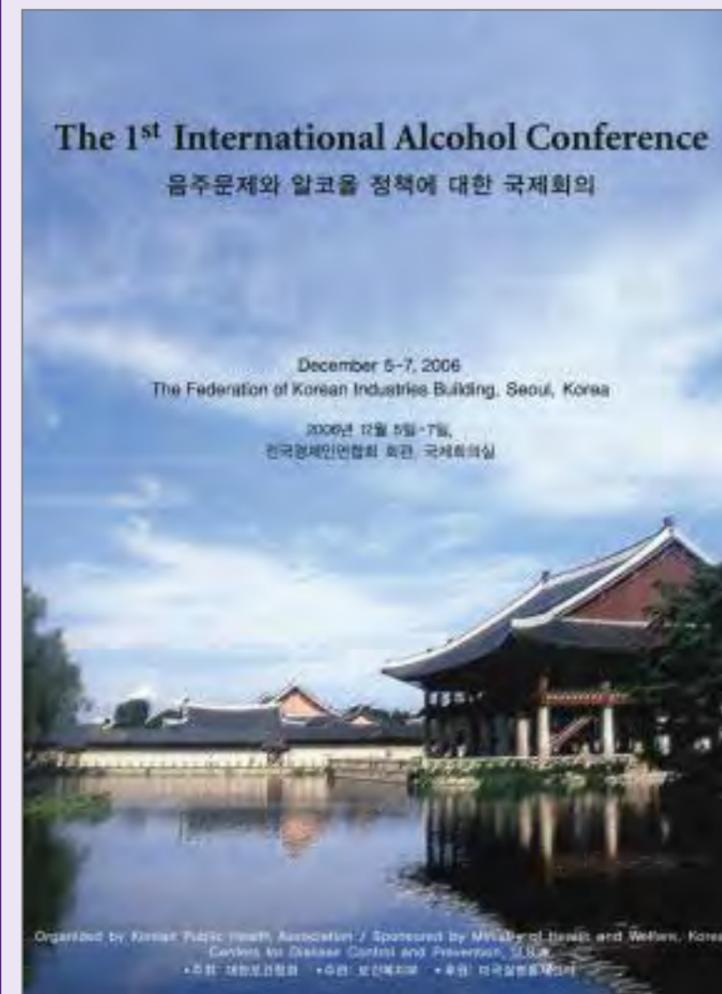
With regard to the alcohol industry, the Committee recommended that WHO continue its practice of no collaboration with the various sectors of the alcohol industry. “Any interaction should be confined to discussion of the contribution the alcohol industry can make to the reduction of alcohol-related harm only in the context of their roles as producers, distributors and marketers of alcohol, and not in terms of alcohol policy development or health promotion”

The Committee recognised that with alcohol being a special commodity in terms of its toxicity and dependence properties, there was need for WHO to protect the public health interest concerning alcohol in trade, industrial and agricultural decisions.

In considering the detrimental effects of alcohol marketing measures on young people, the Committee recommended that WHO support and assist governments:

- to effectively regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and of sponsorship of cultural and sports events, in particular those that have an impact on younger people;
- to designate statutory agencies to be responsible for monitoring and enforcement of marketing regulations;
- to work together to explore establishing a mechanism to regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and sponsorship, at the global level.

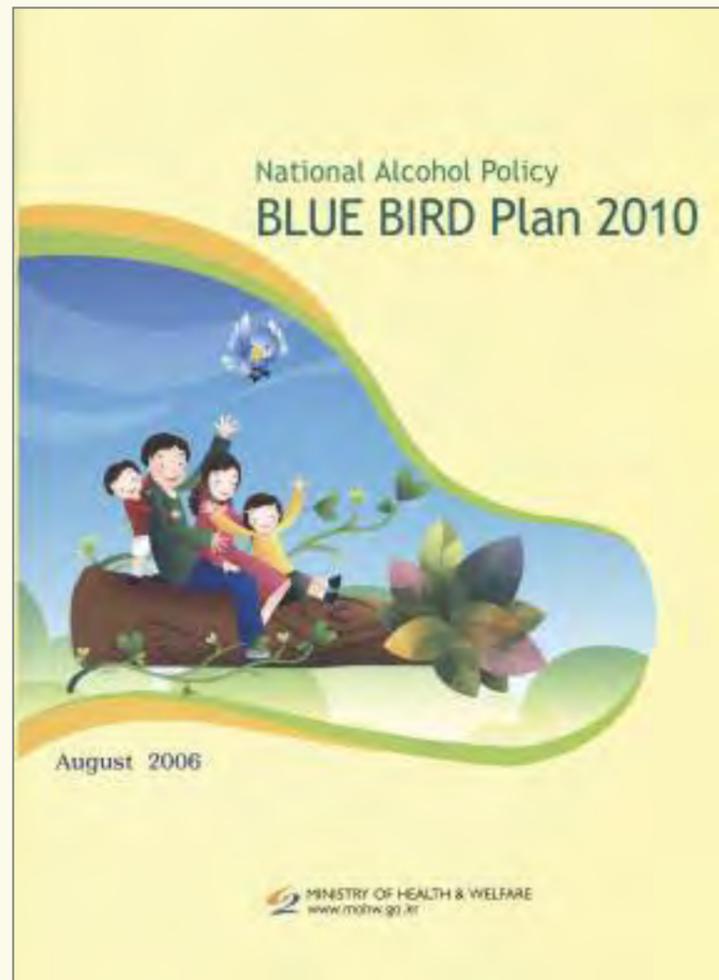
International Conference on Alcohol held in Seoul, Korea



The first international conference on alcohol to be held in Korea, took place in Seoul in December 2006. The conference was organised by Dr Sungsoo Chun of the Graduate School of Health, Science and Welfare and Director of the Korean Institute of Alcohol Problems supported by the Ministry of Health and Welfare, Korean Public Health Association and WHO.

Among the papers presented to the Conference, which we report, were The Blue Bird Plan 2010, Fetal Alcohol Syndrome, Alcohol Policy in Thailand, Japanese Adolescent Drinking and a Conference Statement.

Blue Bird Plan 2010



The Blue Bird Plan, a national alcohol policy launched by the South Korean Ministry of Health and Welfare in August 2006 was outlined at the conference.

Health officials are aware that the traditional drinking culture and social acceptance of alcohol abuse are barriers to alcohol policy and that "society is not ready to take a firm attitude to the alcohol industry due to a lack of awareness on alcohol related harm". 6.8% of the total population have a drinking problem or are dependent.

The socio-economic cost of alcohol is around 14.9 billion US dollars each year and it will be 2.86% of GDP; 22,000 alcohol related deaths each year (8.7 of all deaths); alcohol related traffic deaths have risen from 379 in 1990 to 1,217 in 2000; and almost two thirds of homicides and violent behaviour are alcohol related.

The goals of the campaign are to: "Improve the quality of life and enhance national competitiveness through alcohol free healthy citizens and happy families by creating a social drinking culture, protecting the public from alcohol related harm and supporting medical treatment and rehabilitation. Create a social and cultural environment open to alcohol control policy. Improve awareness on alcohol harm. Reduce risk factors with early detection of high-risk groups, vulnerable groups and alcohol dependent people. Strengthen treatment and rehabilitation nurturing human resources - alcohol experts and volunteers; and create a social and cultural environment open to alcohol control policy."

To measure the success of the campaign, targets have been set, which it is hoped will be reached by 2010. A decrease in per capita consumption from 9.3 to 8.4%; decrease in high risk drinking among males from 14.9 to 13%; and decrease in youth drinking from 29.6 to 25.0%.

Fetal Alcohol Syndrome

Dr Hari K Atrash, Associate Director for Program Development, National Centre on Birth Defects and Developmental Disabilities, USA, gave a major presentation on the Fetal Alcohol Syndrome. The Globe felt it appropriate to print the lecture in full due to the growing use of alcohol among teenage girls and young women.

For many years the US Health Authorities have warned pregnant women not to drink. The UK Health Department has recently given the same advice.

Dr Vivienne Nathanson, Head of BMA Science and Ethics, said: "The UK has one of the highest levels of binge-drinking in Europe and the highest rate of teenage pregnancies in Western Europe. Many women will not know they are pregnant during the early part of pregnancy, during which time they may continue to drink in their pre-pregnancy fashion with no awareness of the risk to their unborn child."

When a mother-to-be drinks alcohol, her unborn child also is exposed to alcohol. The common misconception that the baby is protected in the uterus from alcohol exposure is completely untrue. Excessive drinking by the mother at any time after fertilization of the egg may result in damage to the developing child.

The possible detrimental effects of prenatal alcohol exposure have been known for some time. Aristotle observed that "drunken women" most often bring forth children like themselves¹. The Bible advised women who will conceive and bear a son to drink no wine or strong drink.²

Modern research has consistently shown, both in animals and in humans, the detrimental effects of prenatal alcohol exposure. In 1973 Drs. Ken Jones, David Smith and associates published two papers

describing a common set of features for 11 children whose mothers were known to be alcoholics or heavy drinkers during their pregnancies. A French physician, Philip Lemoine, also had described a similar pattern of anomalies previously in the French medical literature in 1967.

Fetal alcohol spectrum disorders (FASDs) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The full syndrome of FAS represents only a fraction of the cases of FASDs, although it is considered most severe consequence of maternal alcohol abuse.

Fetal alcohol spectrum disorders include other conditions, in which individuals have some, but not all, of the clinical signs of FAS. Some other terms used to represent children within this spectrum include: Partial Fetal Alcohol Syndrome (pFAS), Alcohol-related neurodevelopmental disorder (ARND), Alcohol-related birth defects (ARBD), and the outdated term of Fetal alcohol effects (FAE - used to describe children without all the features or children with very mild effects.

1. Aristotle Problemata
2. Judges Chapter 13 verse 7.

Editor' note: this passage refers to the conception of Samson. His mother had to take the vow of the Nazirite which included among other things not to take any wine or other fermented drink.





Slide 4

FASD Characteristics

- Children with FASDs have one or more of the characteristics or exhibit the behaviors outlined below:
- Physical and Facial abnormalities such as small eye openings, thin upper lip, and smooth ridge under their nose.
 - Growth problems, including possible microcephaly.
 - Central nervous system abnormalities, including structural, neurological or functional difficulties. Common functional problems include:
 - poor visual-spatial/motor skills,
 - attention problems,
 - difficulties with math,
 - learning disabilities
 - immature social-language skills.

Spectrum of outcomes

Source: Streissguth A. A long-term perspective of FAS. Alcohol Health & Research. 1994.18(1):p.77

The damage caused by prenatal alcohol consumption to the central nervous system is by far the most serious of all the other effects seen. This CNS dysfunction might be physical (e.g. microcephaly) neurological (poor coordination) or cognitive/behavioral (developmental delay or even mental retardation, learning problems, attention problems, or problems with communications and social interactions).

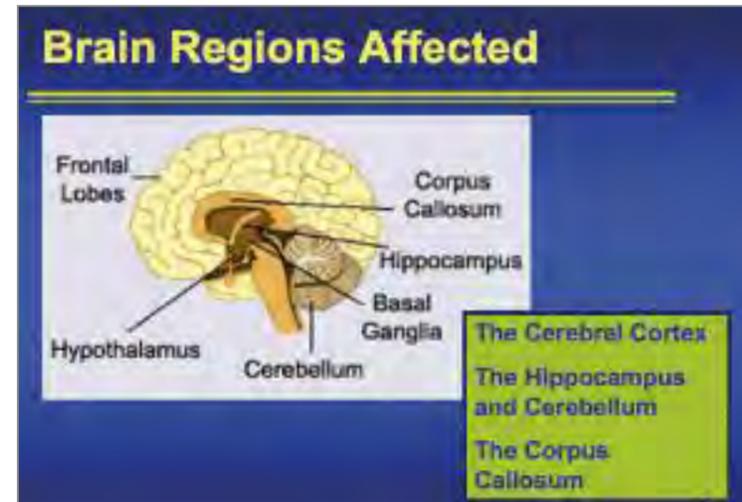
Growth/Facial Anomalies:

- Growth deficiency and facial anomalies of children with FASDs can be quite varied, but a few cardinal features used to make the diagnosis include:
- Small, widely spaced eyes (known as small palpebral fissures).
 - Smooth, wide ridge under the nose (known as a philtrum) (Slide 9).
 - Thin upper lip (known as vermilion border)
 - Small height or weight (either before or after birth).

- In addition to these cardinal physical features, several other associated features may be present, including:
- Flat midface.
 - Small upturned nose.
 - Small head circumference.
 - Unusual palm creases.
 - Curved fingers.
 - Ear anomalies.
 - Folds on the inner eye (known as epicanthal folds).
 - Small teeth (known as micrognathia).

Slide 8

Slide 9



Slide 10

Brain Effects

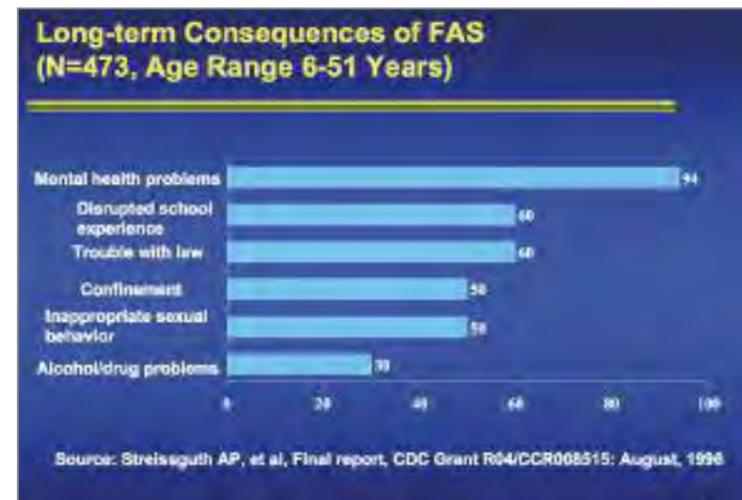
Significant structural changes have been described in animal models and humans having FASDs in the cerebral cortex, hippocampus and cerebellum as well as pathways connecting the two halves of the brain, such as the corpus callosum. Recently, magnetic resonance imaging (MRI) has made it possible to examine the brains of living individuals with FAS. These scans indicate that individuals with FASDs can have abnormalities in several different brain structures: corpus callosum, basal ganglia and the rostral portion of the cerebellar vermis have been shown to be structurally deficient. These deficiencies are not repairable. The effects of maternal alcohol abuse clearly cause brain damage that lasts a lifetime!

Growing up with FAS

Children with FASDs grow up and may experience grave problems trying to cope with the deficits that impact on much of their daily living. Learning is difficult, making friends is difficult, and understanding many of the subtle aspects of adult life can be difficult. Anyone who experiences these difficulties can become frustrated and lash out in negative ways, including individuals with FASDs. In addition, poor social judgments combined with a desire for friends and companions can lead persons with FASDs into dangerous situations and allow them to be taken advantage of by others.

Long Term Effects

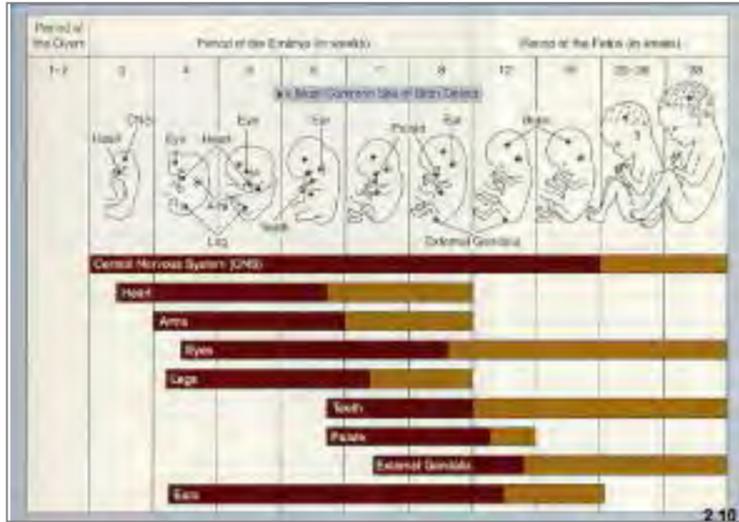
In addition to primary problems that children with FASDs come into the world with, they can also develop secondary problems as they navigate through life. The diagram shows the results of a cohort of children with FASDs who were followed over time. Mental health problems were almost universal. About two thirds had disrupted school experiences or trouble with the law. About half had been confined by incarceration or inpatient treatment, and about one third had problems with alcohol and drugs. Many will never be able to live independently without an adult to supervise them.



Slide 12

Prevalence

Prenatal alcohol exposure is a leading preventable cause of birth defects and developmental disabilities in the USA (Pediatrics.2000;106:358-61) and most likely abroad in countries with similar alcohol consumption



Slide 14
Development of the Embryo

Source: Coles C. Critical periods for prenatal alcohol exposure. Alcohol Health & Research World. 1994. 18(1).p.23.

patterns. We don't know the exact prevalence of FAS. The prevalence depends on the population studied and the methods used for the studies. Rates vary from 0.2 to 1.5 per 1000 live births in the USA. The conservative overall estimate is 1 per 1,000 live births. The incidence of Alcohol-Related Neurodevelopmental Disorders (ARND) is estimated to be at least twice as high as that of full-blown FAS (Teratology. 1999;60(2):51-52).

Estimates for different ethnic groups obtained from studies sponsored by the Centers for Disease Control and Prevention range from 0.3 in the general population to up to 5.6/1000 live births in the American Indian/Alaska native population.

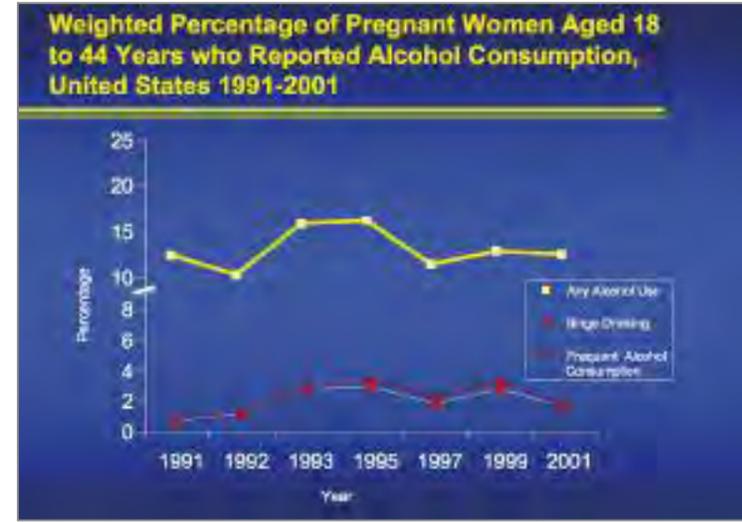
Organs Affected

Different organ systems can be affected at different points during pregnancy. Diagram (slide 14) illustrates the development periods for many organ systems. Vulnerability of the fetus to alcohol-related defects may occur during these periods. Note the darker portion of the bars represents the most sensitive periods of development, during which teratogenic effects on the organs listed may result in major structural or functional abnormalities in a child. The lighter portion of the bars represents periods of development during which physiological defects and/or minor structural abnormalities would occur. This is particularly important since one or more birth defects may be associated with fetal alcohol exposure that include abnormalities of the eyes, ears, heart, kidneys or limbs as well as the brain and face.

Note the extensive period of time during nervous system development that is represented as a period being MOST sensitive to a teratogenic substance, such as alcohol.

Drinking in Pregnancy

Graph 1 represents the proportion of women in the United States who drink at different levels during pregnancy. The yellow upper line represents those who reported drinking at least one or more drinks in the past months. There have been some fluctuations but there is no significant change in the rate over the past ten years. About 1 in 8 pregnant women are drinkers. The bottom blue line shows the number of women who binge drink, and the red line is the number who drink 7 or more drinks per week and/or binge. Frequent drinking and, in particular, binge



Slide 15

drinking carry the greatest risk of producing some of the most severe results. This rate has also not changed over the past 10 years and stands at about 1 in 30 pregnant women.

Drinking Outside Pregnancy

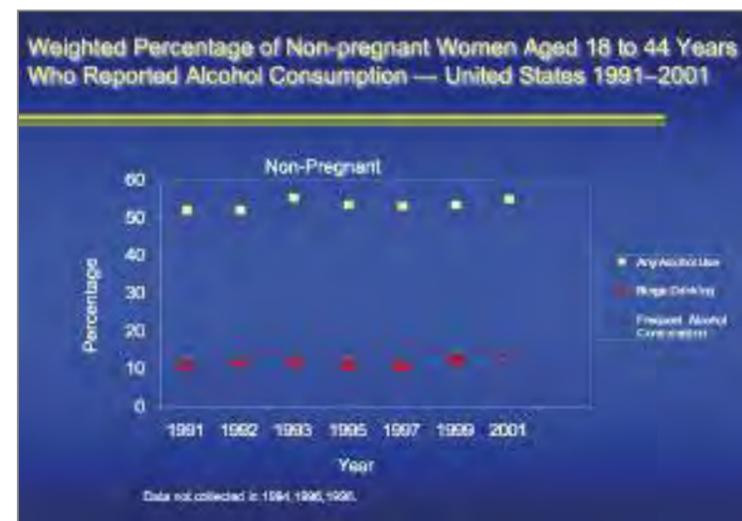
What is of further concern is the number of women of childbearing age who drink alcohol at the higher levels as noted in Graph 2. This is because many of them will become pregnant and not know it and continue drinking at levels that can be hazardous to the developing fetus. In the USA 1 in 8 non-pregnant childbearing aged women drink at those levels. 52% report drinking one or more drinks in the past month.

Prevention

Preventing prenatal alcohol exposure is relatively simple in concept. In short, one must keep alcohol and pregnancy from mixing. Either abstaining from alcohol use, or not becoming pregnant can accomplish this.

FASDs are completely preventable if a woman does not consume alcohol in pregnancy. However, everyone wants to know "how much is too much?" Although alcohol-related birth defects are believed to be induced in a dose response manner, low dose effects are very difficult to assess scientifically in human populations. Whether there is a threshold below which alcohol can be consumed without harming the conceptus is not known. Also, due in part to individual variability (susceptibility), research will not be able to provide an accurate answer for everyone.

Slide 16



Considering that problems resulting from prenatal alcohol consumption are life long, the best advice is to totally abstain from alcohol use during pregnancy, even at stages prior to the time that pregnancy is recognized.

Primary Prevention Recommendations

For these reasons, in the USA, it is recommended that:

1. A pregnant woman should not drink alcohol during pregnancy.
2. A pregnant woman who has already consumed alcohol during her pregnancy should stop in order to minimize further risk.
3. A woman who is considering becoming pregnant or at risk of becoming pregnant should abstain from alcohol.

4. Recognizing that nearly half of all births in the United States are unplanned, women of childbearing age should consult their physician and take steps to reduce the possibility of prenatal alcohol exposure.
5. Health professionals should inquire routinely about alcohol consumption by women of childbearing age, inform them of the risks of alcohol consumption during pregnancy, and advise them not to drink alcoholic beverages during pregnancy.

Prevention Strategies

In general, the prevention of FASDs and their consequences involves three levels of action:

- **Primary Prevention:** In the case of FAS, this would include informing the public, particularly young people, about the dangers of drinking during pregnancy and on a broader level, addressing determinants of health.
- **Secondary Prevention:** Strategies should include screening and early intervention programs and services for pregnant women and women of childbearing potential who may be at high risk for having a child with FAS.
- **Tertiary Prevention:** Strategies should include diagnosis and intervention programs designed specifically for children with FAS and their caregivers; identification and treatment for women and their partners who already have one FAS child and plan to have more children; and identification and treatment of women who are not currently pregnant but who are at risk of becoming pregnant and currently engaging in risky drinking (binge drinking or frequent drinking).

Tertiary Prevention Challenges

Tertiary prevention involves diagnosis of FAS/FASDs and referral for proper management and treatment. However, until recently, no specific and uniformly accepted diagnostic criteria have been available. The four broad areas of clinical features that constitute the diagnosis of FAS have remained essentially the same since first described in 1973: selected facial malformations, growth retardation, Central Nervous System (CNS) abnormalities, and maternal alcohol consumption during pregnancy. These four areas were reaffirmed in a 1996 report by the Institute of Medicine (IOM; 39-40). These broad areas of diagnostic criteria are not sufficiently specific to

ensure diagnostic accuracy, consistency, and reliability. For example, clinicians do not have guidance about how many facial features must be present or the timing and severity of growth retardation needed to constitute FAS diagnostic criteria. Thus, health providers are hampered in their efforts to screen and identify children with FAS.

Additional challenges for tertiary prevention include:

- **FAS diagnosis is based on clinical examination of features, but not all children with FAS look or act the same.** Because each of the symptoms has a broad range of differential diagnoses, it is easy for a clinician to miss or misdiagnose FAS.
- Lack of knowledge and misconceptions among primary care providers. Many professionals believe that FAS can only occur if the mother is an alcoholic. Few know about the full range or progressive nature of the neurobehavioral symptoms that result from prenatal exposure to alcohol.
- Being unfamiliar with the diagnostic criteria that distinguishes FAS from other alcohol-related conditions. CDC, in conjunction with the National Task Force on FAS/FAE recently published updated guidelines for FAS that can be accessed at <http://www.cdc.gov/ncbddd/fas/default.htm>.

Alcohol policy in Thailand

Dr Supreda Adulyanon of the Thai Health Foundation outlined the development and alcohol policy in Thailand.

In 2001 the Thai Cabinet published the Thai Health Promotion Foundation Act establishing a financial mechanism for health promotion. Thai Health was to receive a 2% surcharge on alcohol and tobacco taxes in order to work as a funding agency for civil movements working to improve the well-being of Thai citizens. One of the major tasks of Thai Health is the Alcohol Consumption Control Programme.

Its aims are reduction of consumption; harm reduction; promotion of sensible attitudes particularly among youth; support for alcohol control measures and strengthening of research. Three key strategies are the creation of knowledge: supporting a social movement and mobilising political action.

The core for alcohol related knowledge activities was the establishment of the centre for Alcohol Studies in 2004. To enhance social participation, health orientated networks, including religious alliances, were supported and coordinated by a StopDrink Network. Hundreds of organizations nationwide, covering various sectors, have proven to be effective partners in alcohol policy advocacy, especially in alcohol control measures and drink driving countermeasures.

Public perception of ThaiHealth's alcohol consumption reduction campaigns have been quite high. Different groups have been targeted by using a variety of methods. Examples include applying religious beliefs during the Buddhist Lent to promote a three-month alcohol free campaign among adults and using celebrities as alcohol free role models for teenagers. Dr Supreda Adulyanon stated "All activities gradually shape the social perception on alcohol and then directly as well as indirectly support the policy movement".

In 2003 Thai Health movement played a crucial role in setting up the National Alcohol Control Committee which includes many governmental sectors – Finance, Interior,

Education, Public Health and the Royal Thai Police office. In the Public Sector the influence of Thai Health has also been seen in the policies of the Tobacco and Alcohol Consumption Control Unit under the Ministry of Public Health. The Bill on Alcohol Beverage Control is expected to be passed by Parliament in 2007 and will establish an alcohol policy agency at national and regional level, increasing the minimum purchase age and introducing a comprehensive prohibition on alcohol advertising.

The activities of Thai Health can be seen against a concern over the rise in alcohol consumption from 0.26 litres in 1961 to 8.47 litres of absolute alcohol by 2001. This dramatic growth was due to economic growth, modern lifestyle and a decrease in the price of alcohol coinciding with rising income.

In conclusion Dr Supreda Adulyanon maintained that there were three reasons for Thai Health's success in the alcohol policy field – flexibility, financial security and effective strategy.

ThaiHealth's complementary and coordinating role, rather than replacing existing structures and agencies and capacity is widely and positively accepted. Even if there is still a long way to go to prove the sustainable achievement of this innovative financial institution, the early lessons from Thai Health should already demonstrate one of the progressive ways of utilising the alcohol excise tax for the national alcohol policy.

Survey of drinking of Japanese adolescents

Professor Yoneatsu Osaki of the Department of Social Medicine, Tottori University Japan outlined data from nationwide surveys in 1996, 2000 and 2004

Japan has experienced a decrease in adolescent drinking prevalence since 2000 according to three national surveys carried out by Professor Osaki and his colleagues on junior and senior high school students in 1996, 2000 and 2004.

The number of self-reporting questionnaires returned by students in 1996, 2000 and 2004 respectively were 115,814, 106,297 and 102,451

The results of the three surveys on prevalence of drinking were as follows:

1996	% Boys	% Girls
JHS	29.4	24.0
SHS	49.7	40.8
2000	% Boys	% Girls
JHS	29.0	25.5
SHS	48.7	42.1
2004	% Boys	% Girls
JHS	20.5	20.00
SHS	36.2	34.1

1996: On 1 day of 30 days prior to survey

1996	% Boys	% Girls
JHS	6.4	3.9
SHS	13.8	6.3
2000	% Boys	% Girls
JHS	5.9	4.1
SHS	14.4	7.8
2004	% Boys	% Girls
JHS	3.9	2.9
SHS	10.0	6.5

Weekly Drinking: (every weekend, several times a week, every day)

Decrease in prevalence was greater among boys than girls and in senior high schools than junior high schools.

Popular types of alcoholic beverages were alcopops, shocu and beer and the proportion of drinkers that drank alcopops or shocu increased. Professor Osaki considered that having no friend was a protective factor on students drinking. The increase in the number of students who reported having no friends in 2004 indicated a decrease in the human network of students thereby decreasing peer pressure to drink.

Professor Osaki concluded:

“Japan experienced a decrease in adolescent drinking prevalence after 2000. A decrease in drinking prevalence in the family (father and older brother), the limitation of sources for obtaining alcohol beverages, and an increase of the proportion of students without friend may contribute to the decrease in drinking prevalence.” However, he did caution that the environment which promotes minor drinking, such as low price of alcoholic beverages and advertisements on alcohol beverages still exists and affects minor drinking. The Japanese government should emphasise countermeasures for preventing minor drinking.

Conference Statement

At the end of the conference delegates agreed to the following statement:

Harmful use of alcohol is associated with serious health and social consequences among individuals, communities and societies at large. Alcohol problems are increasing in magnitude and severity around the world in many countries, including Korea, but tend to be given less attention than they deserve. In response to this situation, the Korean Public Health Association, with the support of the Ministry of Health and Welfare, held the First International Alcohol Conference in Seoul, Korea for three days, 5-7 December 2006. Among the participants of this conference were 16 foreign alcohol experts associated with international organizations, governmental research institutes, universities, and non-governmental organizations in 11 different countries around the world.

All the participants, fully appreciating the resolution of the World Health Assembly on public health problems caused by harmful use of alcohol and the regional strategy endorsed by the Regional Committee of WHO Regional Office for the Western Pacific, agreed to appeal to governments, civic societies, professional organizations, non-governmental organizations and all who are involved in alcohol policy and programmes:

1. We recognize that governments and society as a whole should have a significant role in protecting people from alcohol related harms since the use of alcohol has a negative impact on not only drinkers themselves but also others including non-drinkers, children and the unborn.
2. We support the attention to prevention and reduction of alcohol related problems in the Korean governmental initiative 'Blue Bird Plan 2010.' In particular, prompt and sustained responses should be attempted to reduce harms caused by the use of alcohol among vulnerable groups, including youth and women.
3. We recommend the development of a long-term plan of institutionalized comprehensive approaches to alcohol related problems, including measures shown to be effective in scientific research and other countries, such as taxation and alcohol pricing,

restriction on accessibility and availability of alcohol, while effectively implementing current policy measures.

4. We recognize that every citizen has a right to live in a social environment where there is no social pressure to drink against one's will and respect for choices not to drink. One way to build such an environment is to put more restriction on alcohol advertisement and sponsorships that may lead to harmful alcohol use.
5. We believe that comprehensive, accessible, affordable and equitable health and welfare services which provide prevention, counselling, protection, treatment and rehabilitation, should be available to those in need, their families and significant others.
6. We recognize a need to institutionalize a funding mechanism to secure financial support for alcohol policy and programmes. This could be done, for example, by either levying surcharge on alcohol or designating a certain amount of alcohol tax for such purposes.
7. Recognizing that alcohol-related problems have health and social dimensions, well-coordinated partnerships and interactions are required to prevent and reduce these problems. Active and appropriate engagement of all concerned is needed, including the government, civic society, health and welfare professionals, alcohol industry and hospitality sectors. An interagency coordinating mechanism should be established for ensuring concerted actions of different sectors in reduction of alcohol-related harms.
8. We urge the nation to invest enough resources into research and evaluation in order to systematically monitor and periodically report on the levels of alcohol consumption and related problems, and to develop strategies and programmes to reduce them.
9. We recognize the need for strengthening international cooperation and collaboration in the area of alcohol policy and programmes with a supporting and leadership role of the World Health Organization and other appropriate international organizations.

December 2006, Seoul, Korea



Mr Robert Madelin: Director General, DG Sanco, European Commission

Formation of a European Alcohol and Health Forum

The European Commission in 2006 adopted a strategy to support Member States in reducing alcohol-related harm. The Commission identified five priority areas:

- Protect young people, children and the unborn child;
- Reduce injuries and death from alcohol-related road accidents;
- Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
- Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
- Develop and maintain a common evidence base at EU level.

A cornerstone to implement the strategy is the adoption of a Charter establishing a European Alcohol and Health Forum. The objective of the Forum is to provide a common platform to all interested stakeholders at EU level that pledge to support actions relevant to reducing alcohol-related harm. Actions to include:

- strategies aimed at curbing under-age drinking;
- information and education programmes on the effect of harmful drinking and on responsible patterns of consumption;
- possible development of efficient common approaches throughout the Community to provide adequate consumer information;
- better enforcement of age limits for selling and serving alcohol;
- interventions promoting effective behavioural change among children and adolescents;
- cooperation to prevent irresponsible commercial communication and sales.

The Forum is to be chaired by the Directorate General for Health and Consumer Protection. The Forum's membership will include participants drawn from umbrella organisations operating at European level, and member national organisations and individual companies provided all are 'willing to engage in concrete and verifiable commitments under the Forum process'.

Members of the Forum will have to subscribe to certain principles which include, among other things, to:

- Agree to the process and objectives set out in the Charter.
- Provide detailed information on the commitments they make towards reducing alcohol-related harm, in the form of an action plan.

For each commitment, the action to be undertaken will indicate the level of relevant current activities in 2005/2006, as a baseline. The aim is that, going forward, Forum members agree to devote an increasing level of effort, beyond what is being done at present.

The action plans will have to indicate measurable objectives; who the owners of the commitments are; how the proposed action would contribute to reducing alcohol-related harm (relevance), the resources allocated to each commitment, a timetable for the implementation, and the dissemination approach to be undertaken.

The action plans will be made public on the Commission's websites, and in publications.

Commitments from umbrella organisations at European level may include actions taken by all or part of their membership. Commitments for action at European level made within the Forum process may need to be implemented in agreement with national or local stakeholders, and in varying ways at national and sub-national level.

The Directorate General for Health and Consumer Protection will take steps under the Public Health Programme to facilitate the independent study of performance of at least some of the commitments implemented within the Forum process. In addition, the Directorate appears determined to get the commitments made by members of the Forum to be monitored in a 'transparent, participative and accountable way' with the involvement of all stakeholders in reviewing progress and outcomes. Members of the Forum have to agree on the necessity to monitor the commitments they make.

Task Forces

Three task forces are to be set up:

Science

This will consist of a maximum of 20 experienced scientists encompassing both research and field work. The group is to stimulate cross EU networking of scientific activities; provide scientific guidance to the Forum, offer guidance on monitoring and evaluation on areas where action by Forum members would have potential for reducing alcohol related harm. Members of the group and experts will be required to file a standard declaration on conflict of interest.

Marketing

This again will consist of 20 people with no more than one member from each of the organisations represented on the Forum and a balanced representation of the different stakeholders will be ensured. The tasks of the group are:

- to examine best practice actions aimed at preventing irresponsible marketing;
- building upon the report of the Directorate General for Health and Consumer Protection on the Advertising Round Table (http://ec.europa.eu/consumers/overview/report_advertising_en.pdf), to examine trends in alcohol advertising and sponsorship;

Continued on page 24

A personal view by Joao Salviano, a youth member of the Forum



The Alcohol and Health Forum established by the European Commission is a step in the right direction and it establishes alcohol related harm as an EU priority.

It will be very easy to criticise a space that brings together all the stakeholders, including the industry, to be consulted and brought onboard into EU's policy making, but one must resist the temptation of criticising a Forum that actually improves the situation, creates a fair space for debate and dialogue, a space for compromise and a space that demands responsibility from its members over their own commitments, which is an innovative approach to this kind of political forum.

The Alcohol and Health Forum is above all a master stroke by the European Commission that created a one way road to policy-making in order to avoid episodes of a recent past where agreements were made in the room and immediately lobbied against in the corridors. The drinks industry representatives at the Roundtable Forum, organised by the European Policy Centre, agreed action which they later lobbied against before even the Commission published its Alcohol Strategy.

The rules are simple: you bring to the forum what you choose to bring, you decide your own commitments, and you will be held responsible for them once in the Forum. This means that the European Commission can now use the commitments and compromises made by the members of the Forum and translate them into EU policy without allowing the chance for backstage manoeuvres, for the Commission will from now on possess the evidence of the commitments and compromises in their hands, and not words in the wind like before.

The EU strategy on Alcohol Related Harm that came out last fall could be seen as weak and disappointing by many but the truth is that amidst the powerful influence of those that do not have a public health interest, which clearly watered down a strategy that should be in place long ago, a skilled Commissioner and an equally skilled Director-General were able to safeguard the minimum conditions for public health to prevail and for the strategy to remain a valuable tool in fighting the related harm caused by inappropriate alcohol consumption.

All that matters now to see is whether the Public Health NGO's will be willing to take the lead and support the EU Commission by joining the Alcohol and Health Forum and once there by bringing their commitments forward in a manner that forces others who don't share the same interests to step up as well and create a true coalition of stakeholders that by private or general interest can assist in the development of policies and programmes that can improve the dramatic situation that originates from the harmful consumption of alcohol.

The Alcohol and Health Forum and its membership is the living proof that alcohol is a serious social, economical and political problem, a priority to be tackled at EU level, and if not by anything else, this is sufficient reason to consider it a success already!

- to examine trends in product development, product placement, sales promotions and other forms of marketing, and
- to make any appropriate recommendations to the Forum.

Youth Specific Aspects of Alcohol

Protecting young people, children and the unborn child is the top priority identified in the Commission's Alcohol Communication.

The task force will be drawn on a similar basis as the previous two. However, on representation there will be a particular emphasis on representative of youth and family organisations. The group's tasks are:

- to examine trends and drivers in drinking habits of young people and of the alcohol-related harm they suffer;
- to examine approaches that have a potential to reduce the alcohol-related harm suffered by young people, and in particular strategies aimed at curbing under-age drinking and drink-driving by young people, actions aimed at promoting responsible selling and serving, and interventions aimed at educating and empowering young people;
- to make any appropriate recommendations to the Forum.

The experience of young people themselves will be duly considered by the Task Force when carrying out these tasks.

The Forum will meet twice a year and will be chaired by the Directorate General for Health and Consumer Protection of the European Commission. The Chair will ensure that a cooperative and action-oriented approach is respected, and that the activities of the Forum are in line with the Charter and with EU established policies.

Open Forum

In order to give interested non-member bodies and organisations from the EU and beyond an occasion to follow the work of the Forum, and make their opinions known, an 'Open Forum' will be convened once per year.

European Youth Forum agrees a Position Paper on Alcohol Related Harm

With the permission of the Youth Forum Bureau we publish their position paper that was adopted by their Council of Members at an Extraordinary General Assembly 27-28 April 2007 in Baku (Azerbaijan).

Executive Summary

Alcohol related harm is an important health and, in particular, social issue for young people. Unfortunately, youth are often depicted as simply a social group misusing alcohol rather than individuals capable of making conscious choices and sometimes the victims of alcohol-related harm. Moreover, youth could also be potential actors who could contribute to addressing alcohol-related issues. In this regard, youth organisations can play an important role through awareness-raising, by providing alternative leisure time activities for youth, as well as by being the space where young people can develop their social and personal skills. As these policies often affect young people, interested youth organisations should also be involved and have a say in the policy-making.

Introduction

Context

While important to everyone, certain health and social issues are often of

particular importance to some segments of society, such as young people. For example, young people are likely to be more susceptible to certain health threats or more affected by particular social problems, but, if supported and given the right information and assistance they can address these issues early in life.

In this regard, youth organisations have an important role to play in social inclusion and health policy-making. Following this, the European Youth Forum (YFJ) and its Member Organisations (MOs) have for years played an active role in the area of social policies. A clear example of an issue which is of particular concern to youth is alcohol related harm. This is the reason why the YFJ convened a Working Group on alcohol policy in 2006, whose work also laid the foundation for this Position Paper.

Aim and Objectives

The European Youth Forum strives for policies that promote the autonomy and well-being of young people. The aim of this paper is to provide a further contribution to the holistic approach of developing such policies while addressing the question of alcohol related harm.¹

A core value for the YFJ, is that young people should be involved and have a say on all policies that affect them; thus, instead of only discussing policies related to alcohol and youth, young people should be involved in setting the agenda of alcohol policy and be able to express their views on the role



Left: Delegates at the Youth Forum Council of Members.

of alcohol in their daily lives. This relates to the objectives of this paper which are to look into the role that youth organisations can play, and to provide a contribution to the current debate on youth and alcohol policy in Europe. Like international discussions on the topic, this paper deals both with recommendations for the national and European level.

Below: One of the groups in Baku discussing the paper.



Background

Alcohol and Youth

Alcohol, if consumed sensibly, can be a positive aspect in life. It also represents a cultural value for several regions of Europe. However, when abused, it can destroy lives and families, and lead to social exclusion and marginalisation. Europe is not only the heaviest drinking region in the world², but alcohol abuse is also one of the highest risk factors for ill-health on the continent.³ Moreover, international research confirms that heavy and frequent drinking when young can lead to a greater onset of alcohol dependence in later life.⁴ Young people are, furthermore, particularly susceptible to the risks posed by alcohol use, with more than 10% of youth female mortality and around 25% of youth male mortality caused by alcohol. In addition to these direct risks, young people are also often the victims of the secondary effects of alcohol abuse – i.e. harm caused through the misuse of alcohol by parents/legal guardians, young peers as well as others (e.g. violence, drink driving, broken families, and domestic violence).⁵

Political Framework

Consequently, a particular regard is often given to youth in policy-documents relating to alcohol on both the national and international level. Examples of the latter are the European Council recommendations on the drinking of alcohol by young people⁶, the European Commission strategy to support Member States in reducing alcohol related harm⁷, as well as the 2001 WHO Ministerial Conference on Young People and Alcohol⁸. In the case of the latter, the conference also included a parallel youth convention advising the ministers on the recommendations.

Policy Recommendations

On all levels of policy-making relating to alcohol and young people, there is a need to involve youth in order to achieve policies that correspond to their real needs. If not, there is a risk of further policies that depict young people solely in a negative way: as a social group simply misusing alcohol rather than individuals capable of making conscious choices and sometimes the victims of alcohol-related harm, or actors who could potentially contribute to addressing alcohol-related issues. Such a portrayal fails to consider that alcohol misuse is prevalent throughout societies and does not discriminate against age. It also neglects the fact that the attitudes young people hold towards alcohol and alcohol consumption are often inherited from adults.⁹ In the formulation of legislation and policy, the fact that alcohol misuse is an intergenerational problem must be considered.

As a result, long-term approaches to address the problem are required, and young people, through youth organisations, should be involved in the formulation and implementation of public policy on alcohol and other issues which affect them. As a European platform the European Youth Forum can, together with interested Member Organisations, keep track of and participate in the policy-making discussions on the international level. Much of the recommendations and discussions carried out in, for example, the EU and WHO are, however, related to actions on the local and national level. Consequently, actions are needed at all levels, including regional and local. Below follows a discussion on some issues of particular concern.

Below: First meeting in Athens of the Working Group on Alcohol Policy of the European Youth Forum that prepared the ground for the statement.



Empowering young people to make responsible choices

A key aim of alcohol policy, for the European Youth Forum, is the empowerment of young people to make responsible and healthy choices when it comes to the use of alcohol. Young people often live within cultures where heavy drinking is encouraged and glamorised. In order to make responsible and healthy choices young people need to be informed, have strong self-esteem, and the possibility of alternative ways of spending their leisure time and having fun. Public policies should be geared towards supporting young people in this regard while striving for the emergence of a culture where young peoples' right to choose not to use alcohol or to use alcohol responsibly is respected.

Changing the image of alcohol use

One of the key actions necessary to empower and support young people in making responsible and healthy choices is a change in the image of alcohol use. The image of alcohol use can be tackled from different angles by positive means through not only raising awareness on alcohol related harm but actively changing public perceptions of alcohol, through innovative ways. In this regard, the impact of alcohol promotion and marketing in different ways should also be considered. The promotion and marketing of alcohol reinforces the current image of alcohol and is often directly or indirectly targeted towards young people. In order for young people to make informed decisions, restrictions on alcohol marketing should be put in place and enforced.

Protecting young people from alcohol abuse by others

Alcohol related harm does not only concern the alcohol consumer, but also people in their immediate surroundings, as well as society as a whole. In this regard, all young people should be protected not only from the harm that can be directly caused to them by alcohol, but also indirectly. This concerns children and youth affected by domestic violence, peer violence, violence in public places, drink driving, broken families, etc. Support should be provided to the victims, laws need to be properly enforced, and prevention should be given through a variety of measures. Examples of such are awareness raising, counselling, provision of more public transportation during night, reintegration into society of people with alcohol problems, and provide shelters for the ones in acute need of a safe environment.



Some of the greatest damage caused by alcohol is that to children of addicted parents. These children and young people are often forced to take responsibility for their parents or family, thus neglecting their studies and personal lives. The social and emotional effects of growing up with addicted parents are often enormous. No one should be forced to grow up in such an environment. Therefore, governments must assure that these children and young people are identified and that effective help is provided to them and their families.

The Role of Youth Organisations

Many youth organisations working in countries significantly affected by alcohol misuse play an important role in influencing public policy to prevent and reduce alcohol-related harm among young people. Moreover, a significant number of other youth organisations have the potential to do the same as they reach out to such a large part of the young population in Europe. Through the activities and programmes youth organisations run, they also contribute to the empowerment and healthy lifestyles of young people. The European Youth Forum will make sure that this role is taken into account in international policy making and that interested youth organisations can take part in these processes.

Education and Training, the Role of Non-Formal Education

Youth organisations provide a very important space in which young people can develop their social and personal skills. Young people learn much from the young person next to them which is why peer learning and youth organisations in general can play an important role in assisting young people to develop self-confidence to make informed choices and develop a responsible attitude. Just as negative peer pressure can lead to young people consuming excessive amounts of alcohol, positive peer pressure from within

Left: Final meeting of the group in Cambridge.

youth organisations can facilitate the development and enhancement of personal skills and self confidence amongst young people. As youth organisations are environments which provide alternative leisure time activities for young people, they contribute to prevention. Thus, youth organisations should be enabled, if they wish, to play an integral part in preventing and reducing alcohol-related harm amongst young people.

Moreover, non-formal education on alcohol misuse is one aspect of the work that not only specialised health agencies, but also youth organisations can deliver. However, it is important to note that such education is only effective as part of a multi-faceted approach to combating alcohol-related harm and on its own is not effective in reducing alcohol related harm. To support the work of youth organisations on alcohol related harm, programmes could be put in place to empower young people and youth workers with methodologies, information, and techniques on how to deal with alcohol abuse. Such initiatives should be supported by sufficient financing on the national and European levels.

Participation

Youth organisations can serve a significant function in many respects, such as raising awareness within families or in society in general, on how to tackle the stigmatisation of alcoholism/alcohol dependence. They can be a bridge, promoting awareness campaigns and meetings in schools between parents and children. Youth NGOs could have the opportunity to play a role in the reintegration of victims of abuse by providing places for young people to participate actively and be integrated into society.

Moreover, being democratic youth-led structures, interested youth organizations should have a say on alcohol policy, and are an important forum for discussing issues. This relates not only to the general public, but also within the organizations themselves, as they are an important space in which young people, through nonformal education methodologies, learn about their responsibilities and how to face these and other related issues. Moreover, an internal discussion on the issues might benefit members that may themselves be affected by problems of alcohol related harm.

While youth organisations provide a space for young people to participate and have fun in a safe and educational environment, they also have a responsibility to be conscious that their activities truly

provide an alternative for alcohol misuse. This is even more important considering that European societies are increasingly multicultural and alcohol use is not part of all cultures. Choosing not to use alcohol should not lead to the exclusion of young people from participating from youth activities. In this regard capacity building on how to tackle or avoid the use of alcohol in youth activities should be provided.

Conclusion

The formulation and implementation of policies related to alcohol abuse and alcohol related harm require the involvement of young people, just as much as young people need effective policies. Youth organisations have a role to play in the formulation of these public policies at both European and national levels. Moreover, youth organisations play an important role with young people in capacity-building, awareness-raising, and influencing their lifestyle choices. This, however, requires that youth organisations which work with young people have the financial resources and support to deliver. Young people need to be supported in order to be able to make informed choices, while ensuring that others, and public authorities in particular, put in place policies and measures to address the problems and consequences of alcohol abuse and alcohol related harm.

References

- 1 This Position Paper should be read in the context of the larger work done by the YFJ in relation to Health, Social Inclusion, Youth Autonomy, Sustainable Development, Youth Policy etc. See for example 0052-04 *Policy Paper on Youth Autonomy*, April 2004; *European Youth Forum Policy on Young People and Social Exclusion*, November 1999; 0182-06 *European Youth Forum Policy Paper on Sustainable Development*, April 2006; and 0070-06 *European Youth Forum Policy Paper on Social Inclusion through Youth Participation*, April 2006
- 2 Both the European per capita consumption and the disease burden from alcohol are twice the world average (WHO. 2005).
- 3 For example, in the EU, alcohol is the third highest of twenty-six risk factors for ill-health - only behind tobacco and high blood pressure. (Anderson, P. & Baumberg, B.).
- 4 For example, young people who begin drinking before the age of 15 are 4 times more likely to develop alcohol problems than those who begin drinking at 21 (Anderson, P. & Baumberg, B). Adolescent binge drinking is of particular importance in this regard.
- 5 Anderson, P. & Baumberg, B. (2006) *Alcohol in Europe*. London: Institute of Alcohol Studies
- 6 See <http://europa.eu/scadplus/leg/en/cha/c11564.htm> for more information
- 7 See http://ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_com_en.htm for more information.
- 8 See http://www.euro.who.int/alcoholdrugs/policy/20020611_1 for more information.
- 9 Anderson, P. & Baumberg, B. (2006) *Alcohol in Europe*. London: Institute of Alcohol Studies

Thai National Marathon supporting alcohol control legislation

Report by
Areekul Kung Puangsuwan of
the Thai Health Foundation

At the end of 2006, The StopDrink Network and its partners from various sectors in Thailand tried to push forward a regulation against alcohol, a total ban on alcohol advertisements on television, radio, billboards and in published media through the Food and Drug Administration (FDA).

Unfortunately, the regulation was not approved because of a ruling by the Council of State (the government's legal advisory body). The Council claimed that FDA had no mandate to control alcohol ads in the media and such a ban should come from the Office of Consumer Protection which is empowered to limit the advertisement of any product causing social, cultural or moral harm. Contacting this Office, the Alliance found that such a ban would only cover locally-brewed alcohol and that local alcohol manufacturers were already highly influential. Therefore, the Network turned its whole effort to another approach, the alcohol control bill, which includes a total ban on alcohol ads.

The draft legislation to control alcohol beverages, with the objective of protecting the Thai population from the harmful use of alcohol, will cover several areas including health protection and marketing controls, areas never before covered by Thai law. At the present time, the National Legislative

Assembly (NLA) has considered this draft legislation and has approved the draft in principle upon its first consideration. A 31-member ad hoc panel was set up to scrutinize the draft legislation ahead of the second reading in about two months time.

If it becomes law, this legislation will:

- raise the minimum age for buying alcohol from 18 to 20 years of age,
- impose a total ban on alcohol advertising including limits at drinking and selling points,
- restrict sales outlets, retailer hours, marketing activities and drinking points,
- fund rehabilitation for those suffering the effects of alcohol abuse, and
- require warning labels on alcoholic drinks.

Even though the law will protect people from the harmful use of alcohol, there is great opposition from interest groups who will be affected by the new law. They are lobbying hard to water down the bill, particularly the provisions banning alcohol advertisement. They claim that the ban on advertising will not solve or reduce social problems arising from alcohol consumption and it would be better if authorities cracked down on cheap, strong liquor, as such drinks lead to social problems. They maintain the bill will affect only expensive drinks that rely on advertising.



Because of strong opposition, on 2nd March 2007, a health-advocacy group began campaigning to collect signatures from members of the public who support the draft legislation. The goal of the activity was to get at least 8 million signatures from all over the country to present to the Prime Minister and the President of the National Legislative Assembly (NLA) at Sanam Luang (Great Royal Lawn), Bangkok, on 18 March 2007.



National Marathon Supporting Demand for Legislation

Quickly, an anti-alcohol network of 246 organizations formed and arranged a National Marathon. The activity was inspired by a 1987 marathon which collected 6 million signatures supporting anti-smoking legislation protecting the rights of non-smokers. In early March, campaign supporters started running from 4 different parts of Thailand; in the north from Chiang Rai, in the south from Naratiwat, in the northeast from Nongkai and in the east from Trad, to finish in Bangkok.

Along the way, campaigners explained to the local people why the alcohol control legislation is necessary for Thai society. They then asked them to sign and support the alcohol control petition. Many people enthusiastically supported this effort. Despite civil unrest in southern provinces like Pattanee and Naratiwat because of terrorism, the activists were not dissuaded and completed their mission despite the dangers involved.

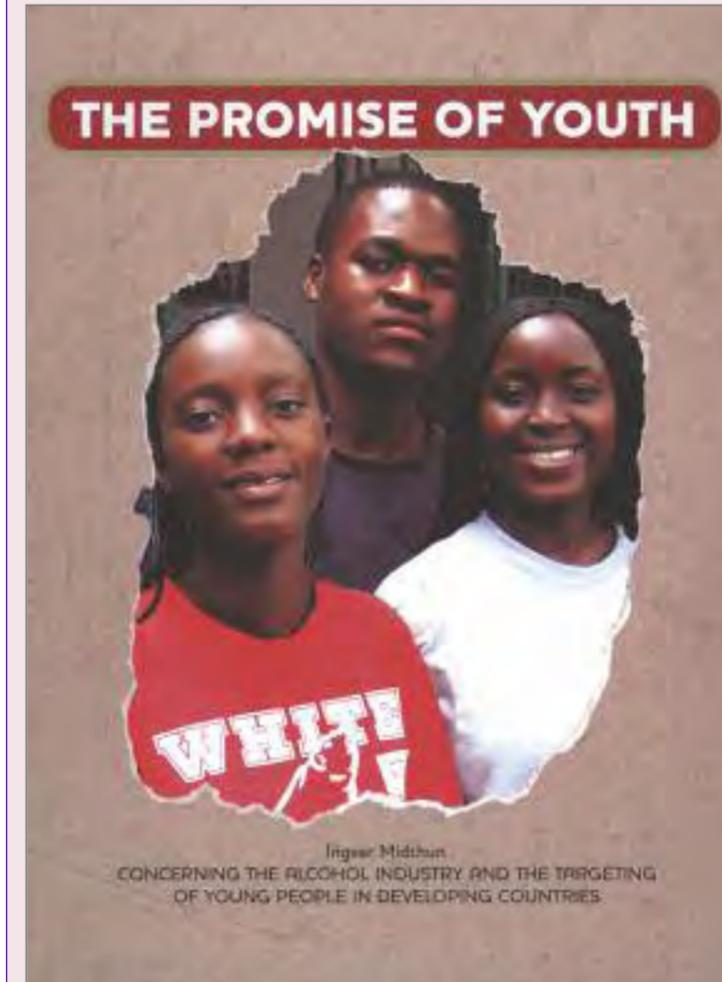
While passing through each province, the marathon runners were welcomed with many activities created to encourage them. Religious leaders and monks blessed and prayed for them. Furthermore, governors and high ranking officials delivered welcome remarks and saluted them. On 11 March in Petchaburee, the Prime Minister, Surayud Chulanont, added his name to

the rapidly growing petition. The activists were very encouraged that the Prime Minister signed the petition because it showed that he recognized the importance of the issue and wanted to keep alcoholic beverages away from adolescents.

Finally, on 18 March, the campaigners from all 4 areas were together at Sanam Luang and presented about 13 million signatures to the Deputy Prime Minister and Minister of Social Development and Human Security (SDHS) to encourage the government and NLA to adopt the draft alcohol control legislation for its effective enforcement before the traditional Thai New Year Festival (13-15 April). In addition, they passed a letter from the Global Alcohol Policy Alliance (GAPA) supporting the alcohol control bill to Minister Paiboon (SDHS).

Minister Paiboon said he believed that the NLA would welcome public input on the bill and pass it, while alcohol business groups should ponder the many positive effects the new alcohol provisions would have for Thai society.

The Promise of Youth



When Kingfisher Airlines was launched in India in December 2004, it was an event that awakened interest, not just because the company was very ambitious but because Kingfisher is primarily a brand of beer. Imagine Carlsberg Airlines. What would that have made you think of, apart from air travel? This is the starting point in 'The Promise of Youth', a new booklet co-published by the Global Alcohol Policy Alliance and the Norwegian based international development agency, FORUT.

The multinational beer and liquor giants have designated the developing countries as the new growth sector for alcohol, since consumption in Western countries appears to be stagnating. They call them emerging markets and consider them promising: low alcohol consumption as a point of departure, economic growth, a growing middle class and increasing spending power. These are countries with a very high proportion of children and youth in the population. The alcohol industry is adapting its strategy accordingly. It is aiming at young people and trying to promote its products and logos with modern, Western, future-oriented, high-technology associations. The Young and Promising provides some snapshots collected from three different countries, India, Sri Lanka and Malawi, by Norwegian journalist Ingvar Midthun. Current developments in these and other developing countries may have dramatic consequences for health and welfare among the world's poor in the course of just a few years.

Flying high

Kingfisher may be alone in flying so high that they literally started their own airline, but this marketing

strategy is common to many: targeting young people and linking drinks and logos to modern, Western, forward-looking, high technology themes.

People who drink are supposed to belong to the élite – the jet-set lifestyle acquires a new meaning when beer and air travel are marketed under the same name. Perhaps India is the clearest example of what the alcohol industry calls ‘emerging markets’: countries where alcohol consumption is low but add on economic growth, a growing middle class, increasing purchasing power, and a high percentage of children and youth in the population.

In such countries the industry sees great potential for increased alcohol sales. However, such an increase will not take place unaided. It must be spurred on. Purchasing power must be steered towards alcohol. A massive focus on lifestyle marketing of global products is aimed at urging young consumers to put beer and spirits high on their lists of goods to be purchased. The result will surely be that the northern European culture of binge drinking will spread around the world.

The investments made by the alcohol industry are producing results. In India from 1998 to 2003 sales of spirits grew by an average of 12.2 per cent – doubling consumption in the course of 5 years! The increase in alcohol consumption in developing countries is characterized by three factors:

- the growth of industrially produced beer and spirits – both in addition to and at the expense of traditional alcoholic beverages;
- a dominant position for multinational companies;
- heavy investment in marketing and advertising.

Industry temptation

These promising prospects regularly become too tempting for the alcohol industry. Often they cross far over the boundaries set out both in national legislation and in the industry's own self regulation. The rules they apply in the West are left behind, and their respect for the limitations inherent in cultural and religious traditions is not particularly impressive.

Some developing countries prohibit advertising for alcohol, but that is no obstacle. Where advertising is banned the industry markets the brand through other products – so-called ‘surrogate advertising’. Sponsorship of sporting events and cultural activities is another often-used method to get around national advertising bans. Product placement in major movies from Hollywood or Bollywood reaches out



everywhere. These are probably more effective methods than advertisements and posters. One of the big multinationals has defined the company's new ‘mission’: to create lasting bonds with consumers by providing them with branded products and experiences that bring people together.

Jet-set life also has appeal in Malawi

Malawi in East Africa is one of the world's poorest nations with a large segment of poverty. The country is number 162 of 175 countries on the UNDP's index on living conditions. Current life expectancy is around 37 years. But they do have beer! The Danish brewery company Carlsberg set its sights on Malawi as early as the 1960s. Now the country is saturated with ‘green’ advertisements for Carlsberg beer.

In Malawi too the alcohol industry tempts potential customers with a taste of the jet-set life. Send in the cork inlay from the beer-bottle and take part in a draw to win a free flight around the world for seven days with seven friends. The contrast with life in rural areas and the daily struggle for survival could hardly be more striking.

With the permission of FORUT we publish from their report the editorial written by Professor Robin Room.

The flood of alcohol and the path of development

For Asia and Africa, as for Latin America and Oceania, economic and social development is the transcendent issue of our time. Some parts of the developing world are doing well; others are lagging behind. If we look at the history of countries that are now economically

developed, we can see that alcohol played a double role in development. On the one hand, industrialization of production and commercialization of the supply of alcoholic drinks was often an early stage of economic development. On the other hand, the flood of alcohol which resulted created enormous social and health problems, and became an impediment also to further development. The new industrial and urban conditions required more, not less, sobriety. In many countries, social movements for alcohol control became the most important and long lasting popular movements. It took over a century of political struggle in such countries as the United States and Norway to reach a settlement on this issue, however unstable.

In some respects, we can see early stages of this history being repeated today in many developing countries, and particularly in those doing better economically. In most places, industrialization and commercialization of the alcohol supply is well under way. Alcohol consumption is increasing rapidly in the better-off parts of the developing world. Along with this comes increased harm. The World Health

Assembly summed it up in a 2005 resolution: “harmful drinking is among the foremost underlying causes of disease, injury, violence – especially domestic violence against women and children – disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities.” As happened historically in the developed world, in some places there have been popular movements to control the alcohol supply and limit the problems from drinking – some examples are the women’s campaigns in India, on the Pacific Island of Chuuk, and in South Africa under apartheid, and community movements in the highland Chiapas of Mexico.

But there are new elements in the current version of the story. Most notably, as illustrated in the pages which follow, industrialization and marketing of alcohol these days is often not a matter of homegrown entrepreneurs, but of multinational corporations. The corporations’ expertise in industrial production is often parachuted in. Their heavy investment in advertising and other promotions also depends for its power on applying techniques learned elsewhere to new markets. On the other hand, much of the profit, as the industry is increasingly concentrated into the hands of multinationals, flows out of the economy of the developing country. The influence of the multinational enterprises, often exerted through the governments of developed countries in trade agreements and disputes, counteracts attempts by communities and governments to limit the damage by controlling alcohol sales. These days, the balance is tipped further to the negative side: in net terms, alcohol is more of an obstacle than it used to be to development.

As the case studies which follow illustrate, much can be done by communities acting at a local level to counter alcohol-related harms. But, given the internationalization of the alcohol industry and market, communities need help at the international level in this effort. This includes international cooperation in such matters as controlling the movement of alcoholic beverages across borders. Most importantly, it involves establishing the principle that alcohol is not an ordinary commodity like rice or clothing, because drinking carries with it such enormous social and health harms. National governments and local communities need to be able to act to control the market and counter the harms

The Promise of Youth can be ordered from FORUT, Campaign for Development and Solidarity, P.O.Box 300, 2803 Gjøvik, +47-61 187400, forut@forut.no Dag Endal and Øystein Bakke, FORUT

without constraint from international trade agreements or from pressure by powerful countries or trade blocs. As for tobacco, there is a need for these principles to be established by an international Convention.

Robin Room, University of Melbourne and Stockholm University

Carcinogenicity of alcoholic beverages

26 scientists from 15 countries met at the International Agency for Research on Cancer (IARC) in Lyon, France, to assess the carcinogenicity of alcoholic beverages. The Working Group reviewed the epidemiological published work on the possible association between alcohol consumption and cancer. Studies have consistently shown that regular alcohol consumption is associated with an increased risk for cancers of the oral cavity, pharynx, larynx, and oesophagus.

Daily consumption of around 50g of alcohol increases the risk for these cancers by two to three times, compared with the risk in non-drinkers. Effects of drinking and smoking seem to be multiplicative. Populations deficient in aldehyde dehydrogenase run much higher risks for oesophageal cancer.

The evidence is strong that the consumption of alcohol is an independent risk factor for primary liver cancer. The effect of alcohol consumption on the risk for liver cancer is difficult to quantify since cirrhosis and other liver diseases often occur before the cancer and patients can have reduced their alcohol consumption when diagnosed with cirrhosis.

More than 100 epidemiological studies that assessed the association between alcohol consumption and breast cancer in women consistently found an increased risk with increasing alcohol intake. Analysis of 53 studies on more than 58,000 women with breast cancer showed that daily consumption of about 50 g of alcohol is associated with a relative risk of about 1:5 compared with that in non-drinkers. Even at regular consumption of 18 g per day the relative risk is significantly increased.

Studies show evidence for an increased risk of about 1:4 for colorectal cancer with regular consumption of about 50 g of alcohol per day, compared with that in nondrinkers. It appears similar for colon and rectal cancer. The evidence points to no increase in risk for renal-cell cancer with

increasing alcohol consumption. In fact in several studies, an inverse trend was seen in both men and women. An inverse association or no association between alcohol consumption and non-Hodgkin lymphoma – most studies showed a lower risk in drinkers than in non-drinkers.

Alcohol consumption might be associated with an increased risk for cancers of the lung and stomach, but it could not be ruled out that this could be confounded by smoking and dietary habits.

Synopsis of a report prepared by Robert Baan, Kurt Straif, Yann Grosse, Béatrice Secretan, Fatiha El Ghissassi, Véronique Bouvard, Andrea Altieri, Vincent Coglianò, on behalf of the WHO International Agency for Research on Cancer Monograph Working Group. Policy Watch WHO

Rand study finds alcohol advertising and marketing are associated with adolescent drinking

Children's exposure to alcohol advertising during early adolescence appears to influence both beer drinking and their intentions to drink a year later, according to a RAND Corporation study released in May 2007.

The study of children in the sixth and seventh grades found that those exposed to alcohol advertising at high levels – from television, magazines, in-store displays and promotional items like T-shirts and posters – were 50 percent more likely to drink and 36 percent more likely to intend to drink than children whose exposure to alcohol advertising was very low.

Previous studies have found that adolescents on average see at least 245 television ads for alcoholic beverages every year, and that these ads may promote drinking. But the RAND study is unique because it also asked adolescents about advertising in magazines, radio and elsewhere, along with whether they owned any promotional items from alcoholic beverage companies.

"Parents may be aware that advertising may promote drinking among early adolescents," said Rebecca L. Collins, a RAND senior behavioral scientist and lead author of the study. *"We did a previous study that found that children as young as fourth grade were very familiar with alcohol advertising and can tell you slogans and brand names. This new study shows that by the time they get to sixth grade, ads may be influencing them to drink."*

"Parents often think they don't have to worry about their kids drinking before they get to high school, but sixth grade — or even before then — is the time to talk with children about alcohol marketing techniques, as well as drinking," Collins added. *"Getting kids to think critically about ads may lessen any effects the ads have."*

The study by RAND, a nonprofit research organization, is titled 'Early Adolescent Exposure to Alcohol Advertising and its Relationship to Underage Drinking' and is available from the Journal of Adolescent Health Web site at www.JAHOnline.org. It will be published in the June issue of the journal.

The study is based on a RAND survey of 1,786 South Dakota sixth graders about their exposure to alcohol advertising and marketing, and a second survey of the same children a year later about drinking intentions and behavior.

"More research is needed," Collins said. *"South Dakota ranks among the top ten states in terms of binge drinking among adolescents, and results might be different where drinking is not as common."*

Besides being illegal, underage drinking has been linked to an increased probability of motor vehicle crashes, sexually transmitted diseases, suicide and disability. The U.S. Surgeon General issued a call to action in March to prevent and reduce underage drinking.

The sixth-graders in the RAND study were the youngest group to be studied longitudinally on alcohol advertising issues. By the time children are in the eighth grade, slightly more than 50 percent have already experimented with alcohol. Those who have not experimented have seen the effects of alcohol on their friends.

By seventh grade, 17 percent of the children surveyed reported that they had consumed

beer in the past year; 16 percent said they 'definitely' or 'probably' would drink in the next six months; 23 percent said they 'probably would not;' and 61 percent they 'definitely would not.'

Like other studies, the RAND research found that television ads, which mostly appear during sports programming, are a key factor. But the RAND study also found that the 19 percent of children who owned a hat, poster or T-shirt promoting alcohol were nearly twice as likely to drink or intend to drink as other youngsters.

"We were a little surprised by how common these promotional items were," Collins said. *"Parents can make a difference by keeping promotional merchandise from their kids. My guess is that many parents think it's harmless: your kid has a Budweiser T-shirt, it's just funny. But it probably is a subtle communication to kids that beer drinking is cool."*

Researchers also found that a child would be more likely to drink if the child's friends approved of drinking and if the child's parents didn't monitor him or her.

Other authors of the study include: Phyllis L. Ellickson, Daniel McCaffrey and Katrin Hambarsoomians, all of RAND. The RAND Health study was funded by a grant from the National Institute for Alcohol Abuse and Alcoholism.

RAND Health, a division of RAND, is the United State's largest independent health policy research program, with a broad research portfolio that focuses on health care quality, costs and delivery, among other topics.

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The Global Alcohol Policy Alliance is a developing network of non-government organizations and people working in public health agencies who share information on alcohol issues and advocate evidence-based alcohol policies.



“Reducing alcohol-related harm worldwide by promoting science-based policies independent of commercial interests”

Board Members

Listed below are the members of the GAPA board elected in April 2006 at a meeting in Geneva:

- Mr Derek Rutherford, UK, Chairperson
- Dr Sally Casswell, New Zealand
Chairperson Scientific Advisory Panel
- Mr Øystein Bakke, Norway, Secretary

- Dr S Arulrhaj, India
- Mr Ross Bell, New Zealand
- Mr Sven Olov Carlsson, Sweden
- Dr Michel Craplet, France
- Mr George Hacker, USA
- Dr David Jernigan, USA
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- Dr Shanti Ranganathan, India
- Dr Srisangnam Udomsilp, Thailand
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Resource centres affiliated to GAPA are already operating in the EU, USA, South America, India, South East Asia and Western Pacific regions. It is envisaged that the Alliance, in the not too distant future, will be able to establish centres in Africa.

History

An international consultation of experts and advocates met in 2001 in the USA to exchange views and experience and to find a way of co-ordinating efforts. At the consultation it became quite clear that there was a commonality of interest in the alleviation of alcohol problems. An urgent need to monitor the marketing strategies undertaken by the global alcohol industry as it seeks to increase sales and circumvent health promotion policies was recognised. Although impossible to match the financial resources of the international drinks companies and the 'social aspect' groups which speak for them, it became clear that with a sharing of scientific knowledge and expertise we could become a united resource in helping governments around the globe to formulate strategies to counter the health and social problems created by alcohol consumption. The meeting resolved that the Global Alcohol Policy Alliance be established.

Mission Statement

The GAPA mission is to reduce alcohol-related harm worldwide by promoting science-based policies independent of commercial interests.

Objectives

- Provide a forum for alcohol policy advocates through meetings, information sharing, publications, and electronic communications; with the purpose to disseminate information internationally on effective alcohol policies and policy advocacy;
- Bring to the attention of national governments, international governmental and non-governmental agencies and communities the social, economic, and health consequences of alcohol consumption and related harm; with the purpose to advocate for international and national governmental and non-governmental efforts to reduce alcohol related harm worldwide;
- Co-operate with national and local organizations and communities to alleviate alcohol-related problems;
- Encourage international research on the social and health impact of the actions of the multinational alcohol beverage industry;
- Monitor and promote research on the impact of international trade agreements on alcohol-related harm;
- Monitor the activities of the alcoholic beverage industry;
- Place priority on research and advocacy regarding those parts of the world where alcohol problems are increasing;
- Ensure that member groups in those areas have the technology and support capacity to participate in a global network for communication and action.



Further publications available from the Institute of Alcohol Studies

Counterbalancing the Drinks Industry

Counterbalancing the Drinks Industry: A Report to the European Union on Alcohol Policy
A response to a report published by the European drinks industry and a defence of the WHO Alcohol Action Plan for Europe.

Alcohol Policy and The Public Good

Alcohol Policy and the Public Good: A Guide for Action
An easy-to-read summary of the book written by an international team of researchers to present the scientific evidence underpinning the WHO Alcohol Action Plan for Europe

Medical Education

Medical Education in Alcohol and Alcohol Problems: A European Perspective
A review of educational programmes on alcohol and alcohol problems in European medical schools, identifying gaps in provision and proposing guidelines for a minimal educational level within the normal curriculum of under- and post-graduate medical students.

Alcohol Problems in the Family

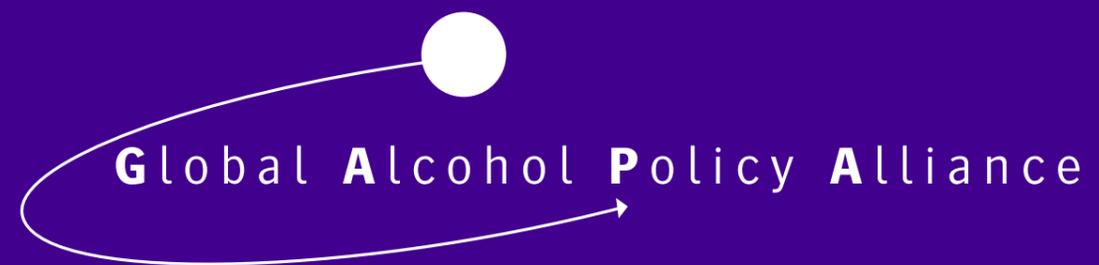
Alcohol Problems in the Family: A Report to the European Union
A report produced with the financial support of the European Commission describing the nature and extent of family alcohol problems in the Member Countries, giving examples of good practice in policy and service provision, and making recommendations to the European Union and Member Governments.



Marketing Alcohol to Young People

Children are growing up in an environment where they are bombarded with positive images of alcohol. The youth sector is a key target of the marketing practices of the alcohol industry. The booklet depicts the marketing strategies of the industry and shows how advertising codes of practice are being breached.





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