

# THE GLOBE

Global Advocacy Grows



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## THE GLOBE

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Design and production: 2b Graphic Design

Published by: The Global Alcohol Policy Alliance

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ISSN 1460-9142

# Vigilance required over WHO collaboration with the drinks industry on a global strategy

This issue of *The Globe* is published at a crucial juncture in the effort to secure a Global Strategy to Reduce the Harmful Effects of Alcohol. Between now and May 2008, when the World Health Assembly will consider the resolution adopted by the Executive Board on 23rd January 2008, global advocates for alcohol policies will need to come to a collective decision to support the process and the resolution as it stands, or seek to amend the request to the Director General to ‘collaborate’ with the ‘economic operators’ by replacing it with ‘to consult with the drinks industry’ on ways they could contribute to reducing harmful use of alcohol.

We have no difficulty with the issue of WHO consulting the Industry. Collaboration is a totally different matter. Section 3.1 of the Principles Governing Relations Between the World Health Organization and Non Governmental Organizations is unequivocal. The article states that the aims and activities shall be in conformity with the spirit, purposes and principles of the WHO and shall be “free from concerns which are primarily of a commercial or profit making nature”. Although this is in regard to official relations between WHO and NGO’s the principle ought to be adhered to with any organisation that collaborates with WHO. What is more the WHO Expert Committee recommended that: “**WHO continue its practice of no collaboration with various sectors of the alcohol industry**”.<sup>1</sup>

*This issue of the Globe is a double edition. Changes have taken place in the editorial staff. Aneurin Owen succeeded Derek Rutherford, formerly chief executive of the Alliance House Foundation, and has undertaken the role of editor of the Globe.*

The Expert Committee recommendation is designed rightly to protect WHO as an expert public health agency from being forced to relate to bodies which not only are outside the public health arena, but which have an obvious potential conflict of interest with the requirements of public health in regard to alcohol. The activities of the alcohol industry are not designed to achieve public health objectives and the industry possesses no relevant expertise in regard to the medical and social harms related to alcohol or to the evidence base underpinning prevention strategies. It is for governments, not the WHO, to accommodate the alcohol industry into the policy making process and to reconcile the interests of the industry with the requirements of public health policy.

Many have worked tirelessly and over many years to move the alcohol agenda forward to where we are today. A Global Strategy is within reach, and NGOs will have legitimacy in both consultation and collaboration with the WHO. The resolution should open the way forward for the adoption of a comprehensive strategy based on the science and effective policies. The Expert Committee Report (see page 15) contains a summary of all the available evidence and is a good basis for building a Global Strategy. The monitoring of the Global Burden of Disease will continue, and other influential groups of scientists and advocates are coming to similar conclusions about the most effective ways of reducing the harmful impact of alcohol (see SHAAP Report page 36).

Significant progress has been achieved and we have reason to celebrate. **So why advocate caution?** The evidence of harm is clear; the data is reliable; the scientific and research communities are consistent in their messages; official documents reiterate the need for action on control policies; advocates are united; the World Health Assembly is on the verge of adopting a Global Strategy; yet the Executive Board acceptance of ‘collaboration’ has left many with a profound sense of unease. Collaboration at WHO level with the industry that produces, markets, distributes and sells a substance that causes untold health and economic harm to countless individuals and their families ought to be resisted at all strategic levels.

1. WHO Expert Committee Report 2007

This scepticism, or realism, is borne out of knowledge and experience of seeing the drinks industry in action and whose main concern is profit for its shareholders. The Editor in Chief had first hand experience of the deviousness of the drinks industry during the 2005/6 Roundtable discussions on an EU Alcohol Strategy between DG SANCO, Member States representatives, NGOs and the Drinks Industry in Brussels. We thought we had left the Roundtable with a general agreement on strategies on which we could find common ground. However, even before DG SANCO published its strategy, the industry were heavily engaged in lobbying the European Parliament and the media against it. In this edition of *The Globe*, by kind permission of Blackwell Publishing and the author, readers will find a copy of a recent editorial from Addictions (About smoke and mirrors: the alcohol industry and the promotion of science – see page 25). The editorial confirms the need to be vigilant. The industry will always attempt to deflect action away from what is proven to be effective policies. They will persuade national governments to adopt all manner of harm reduction policies that are clearly ineffective and that pose little or no threat to their economic ambition.

Other articles in this edition confirm the need for global action. SEARO’s Symposium (see page 4) held in Bali and the reports produced by PAHO (see page 32) set out the enormity of the burden attributable to alcohol across communities and regions. Reference is also made in this edition to Thailand’s response and we highlight the very real danger faced by Cambodian women as they work to promote beers. A call for action resounded from the Commonwealth Medical Association conference in Chennai as Dr Arulraj was installed as president. (see page 30)

National and regional calls for action will need to echo in Geneva.

Alcohol advocates have a clear responsibility to safeguard the integrity of the decision-making processes at WHO by alerting their respective Member States to the risks of WHO collaboration with the industry.

# Reducing harm from alcohol use in the community

Symposium held in Bali, Indonesia

4-6th October 2007

Organised by The Mental Health and Substance Abuse Unit (MHS) of the World Health Organization, Regional Office for South-East Asia

## Opening Address to the symposium

by Dr Samlee Plianbangchang,  
Regional Director,  
WHO South-East Asia Region

It is with great pleasure that I welcome you all to the Symposium on Reducing Harm from Alcohol Use in the Community. This symposium, I am sure, will be of great help as we embark on a programme to reduce harm from alcohol.

In recent years awareness about harm from alcohol use has increased not only with regard to the user but also harm to the family, the community and the entire nation. Traditionally alcohol use has been considered a matter of personal choice and only harm has been seen as a matter to be addressed by the individual and the family. In our Region, community action against harm from alcohol use has been limited to sporadic confrontations between alcohol suppliers and women's groups. However, we now realize that a coordinated multi-sectoral approach is needed to address the complex issues of prevention of harm from alcohol use.

Before suggesting some points for your consideration, I would like to highlight the current situation of harm from alcohol use in the community.

WHO has estimated in its *Global Status Report on Alcohol 2004*, that there are about 2 billion people worldwide who consume alcoholic beverages, and 76.3 million with disorders arising out of harmful use of alcohol. A causal relationship between alcohol use and over 60 types of diseases and injury has been documented. Unintentional injuries account for around one-third of the 1.8 million deaths due to alcohol. These data clearly point to a huge burden of harm.

Moreover, in the South-East Asia Region studies have indicated that health, social and economic harm from alcohol is widespread. On average use of alcohol has been on the increase in the Region, imposing numerous challenges on policy-makers, professionals, civil society and public health. This is well documented



by WHO/SEARO in its series of publications on alcohol use.

The Fifty-eighth World Health Assembly in May 2005 adopted resolution WHA58.26, requesting the Director-General, among others, to collaborate with Member States, intergovernmental organizations, health professionals, nongovernmental organizations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption. The Fifty-ninth session of the WHO Regional Committee for South-East Asia held at Dhaka, Bangladesh in September 2006, debated various policy options on reducing harm from alcohol use. It adopted resolution SEA/RC59/R8 which requested the Regional Director among other measures to hold a biennial regional forum of key partners from Member States and other international partners to share progress, experiences and lessons on alcohol control programmes.

Socio-cultural, political, geographic and religious diversity are the hallmark of the South-East Asia Region. Such diversity leads to many different behaviour patterns and perceptions related to the use of alcohol, not only between countries but also within countries. For example, communities with similar religious beliefs may have different levels of use and harm from alcohol use.

There are also many unique features of alcohol consumption in the Region. For example there are large abstinent populations in many countries, and consumption among women is quite low. But among alcohol users, the number of people abusing alcohol is substantial. Also, there are many patterns of alcohol use that are very deleterious, for example, binge drinking, pay-day drinking, driving while drunk, consuming illicit alcohol, home brewing of alcohol and domestic violence linked to alcohol. The relationship between alcohol and poverty is a major concern in our Region.

Though there is a large body of information related to alcohol use, policies and interventions around the world, it should not be assumed that transplanting measures found to be successful elsewhere, under completely different circumstances, is appropriate for our Region. This is because culture plays an important role in alcohol use. Whatever programmes are developed should be culturally appropriate.

To address the issues of harm from alcohol use community empowerment is essential. Unless communities own the interventions, their sustainability cannot be guaranteed. We are very well aware that controlling and minimizing harm from alcohol is beyond the capacity of the health sector alone. In addition to health, issues related to economics, trade, commerce, legislation, law, enforcement, education and research are included. Therefore, a sustained and coordinated approach addressing all these spheres is needed to address harm from alcohol. This symposium is bringing together multiple stakeholders to discuss the contribution different disciplines can make. But please remember, we not only need new ideas, we also need to operationalize them.

I look forward to new and innovative ideas emerging from this symposium. Any new idea, however, needs to be assessed for its appropriateness and impact. So, as you proceed, please build into your programmes the element of impact evaluation. Appropriate measures of impact should be developed so that the burden of suffering in the community can be reduced. This is our ultimate goal. I hope this symposium will further strengthen WHO's initiative to assist Member States in the area of prevention of harm from alcohol use in the community.

The Symposium considered a wide spectrum of policy and practice responses to alcohol related harm across the South East-Asia Region. In this report we summarise some of the papers given at the symposium.

The harmful use of alcohol causes considerable public health problems and is ranked as the fifth leading risk factor for premature death and disability in the world stated *Dr Vladimir Poznyak, Coordinator of the Management of Substance Abuse, Department of Mental Health and Substance Abuse at WHO*, at the opening of the symposium. He went on to say that in 2002, 2,300,000 people died worldwide from alcohol related causes and that 64,975,000 disability-adjusted life years (DALYs) were lost due to alcohol related causes.

Referring to a number of studies in relation to alcohol-related social harms, he pointed out that:

- from 10% to 69% of suicides are committed under the influence of alcohol;
- 80% of homicides in Russia and
- 33% of divorces in the UK are alcohol-related, and
- between 5% to 14% of parents abusing their children in Japan have alcohol use disorders or a drinking problem.

The Adult Per Capita (APC) consumption levels in the WHO South-East Asian and Western Pacific Regions (WHO Global Alcohol Database) have been increasing across the region from the 1960s and the prevalence of alcohol use disorders is a major cause for concern.

Dr Poznyak ended with the extent of the activities of WHO Regional Offices following the WHA resolution 2005:

**EURO:** Framework for Alcohol Policy in the WHO European Region – resolution adopted by the Regional Committee for Europe;

**AMRO 2005:** First Pan American Conference on Alcohol Public Policies;

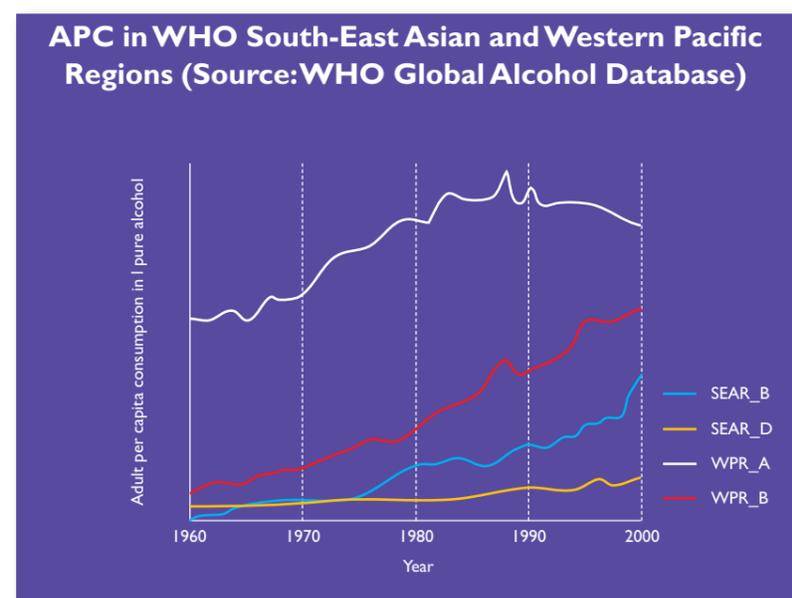
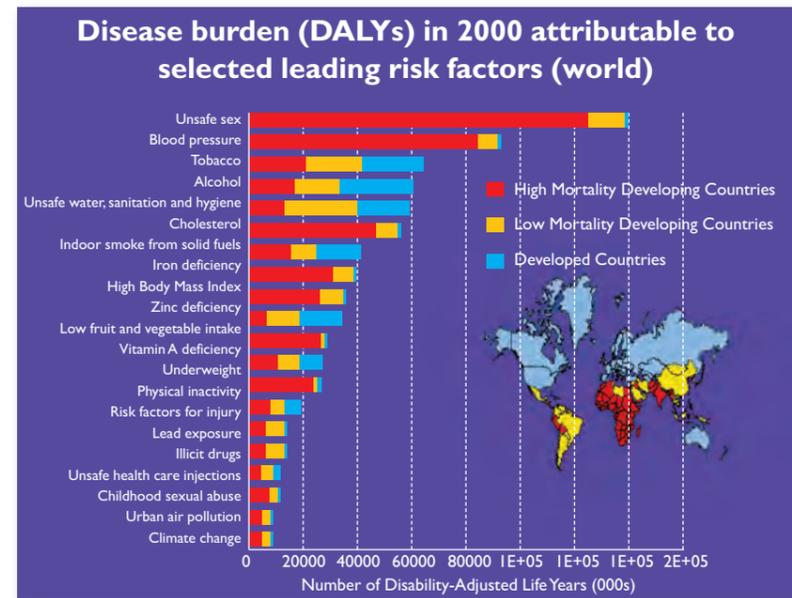
**SEARO 2005:** Resolution on public health problems caused by harmful use of alcohol adopted by the Regional Committee, August 2006;

**EMRO:** Resolution adopted by the Regional Committee (2006);

**WPRO:** Regional strategy developed and endorsed by the Regional Committee (September 2006);

### A WHO Collaborative Study on the global cost of Alcohol and Injuries due to the harmful use of alcohol had estimated the following (millions \$US):

Illnesses	50,000 – 120,000
Premature mortality	30,000 – 55,000
Consequences of drink-driving	30,000 – 55,000
Absenteeism	30,000 – 65,000
Unemployment	up to 80,000
Criminal justice costs	30,000 – 85,000
Criminal damage	15,000 – 50,000
<b>A total of</b>	<b>210,000 – 665,000 (0.6-2.0% of global GDP)</b>



**AFRO:** Technical consultation on public health problems caused by harmful use of alcohol, May 2006; discussion of the report of the Regional Director on harmful use of alcohol in the African region at the Regional Committee in August 2007.

On the theme of **Alcohol and Health**, *Professor R Ray, Chief of the National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi*, noted the extent and magnitude of alcohol use and dependence in India, Sri Lanka, Myanmar, Nepal and Thailand.

**India:** 21.4% of adult males current alcohol users and among women 5% across studies; 44-62% dependent on alcohol among those attending treatment centres.

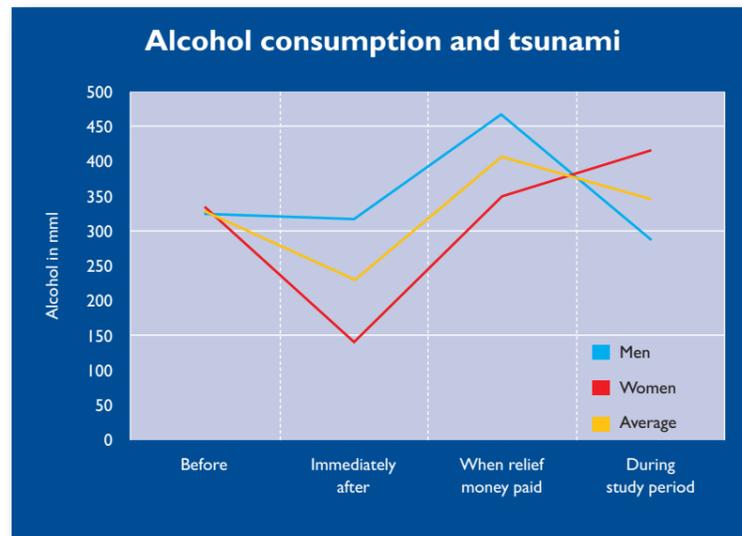
In the mid 1990s a hospital based study showed 12% of all admissions had alcoholism and alcohol accounted for around 31% of the all liver disease, 42% of total cases of liver cirrhosis.

**Sri Lanka:** 53.1% of males above 15 years old are current alcohol users; a survey of 150 randomly selected GPs showed that 80% were frequently confronted with alcohol misuse related problems. From 1975 to 2002: increase in deaths from liver diseases from 3.8 to 15.2 per 100,000.

**Myanmar:** A Community household survey in Daw Pone township of 825 households (5106 subjects) showed that 23/1000 population (7% of males over 18 years) were alcohol dependent. A hospital study based on Madalay Mental Hospital found that 27.8% of patients had alcohol related disorders.

**Nepal:** A community household survey in 2003 of 2,344 adults in Dharan showed a prevalence of alcohol dependence of 25.8%. A 2002 demographic and health survey showed that 67% of the males (15- 60 years) were alcohol users and the largest percentage (73.3%) was the in 25-29 year age.

**Thailand:** Alcohol is estimated to be the third most important health risk factor in the country - 56% males and 10% females consume alcohol. A cross-sectional community survey of 2 urban/5 rural areas in Southern Thailand using AUDIT: 1,005 subjects aged 35 years or more noted a 10% prevalence of hazardous-harmful drinking (27% in males/ 1% in females). 62% of traffic accident victims had a positive blood alcohol concentration and 45% of deaths from traffic accidents are due to alcohol consumption.



Dr Ray referred to the cross cultural study carried out by WHO on the alcohol use and sexual risk behaviours in eight countries including India (2004) which found:

- key patterns of interaction between alcohol use and sexual behaviour across the cultures
- use of alcohol was associated with high risk sexual behaviour in terms of a denial and neglect of risk as a way of coping with life
- use of alcohol-serving venues as contact places for sexual encounters.

**The Bangalore Study on the Burden and Socio-economic Impact of Alcohol** undertaken by **Gururaj G, Girish and N, Vivek Benegal** of the **Departments of Epidemiology and Psychiatry, NIMHANS, Bangalore**, was presented by **Dr Girish**.

Against a backdrop of increasing consumption and accelerated process of globalisation they noted significant changes in patterns of consumption resulting in alcohol disorders becoming the 'number one' burden among all non-communicable disorders. These changes are:

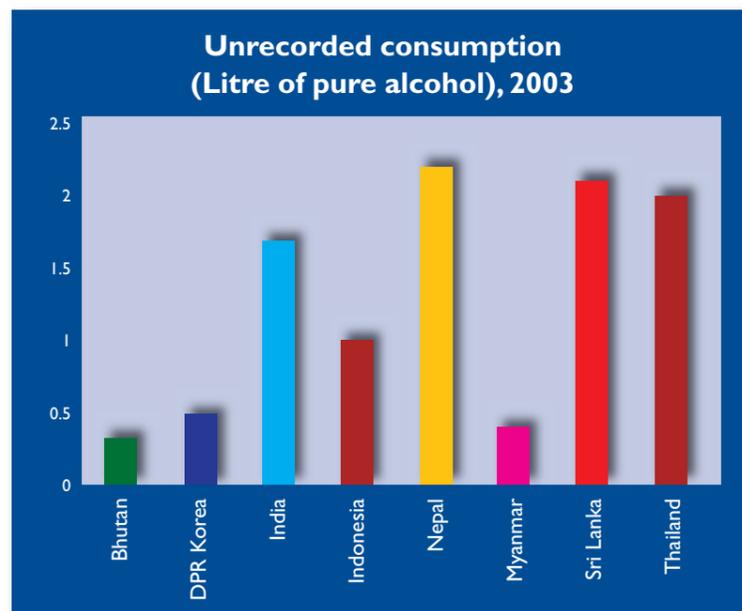
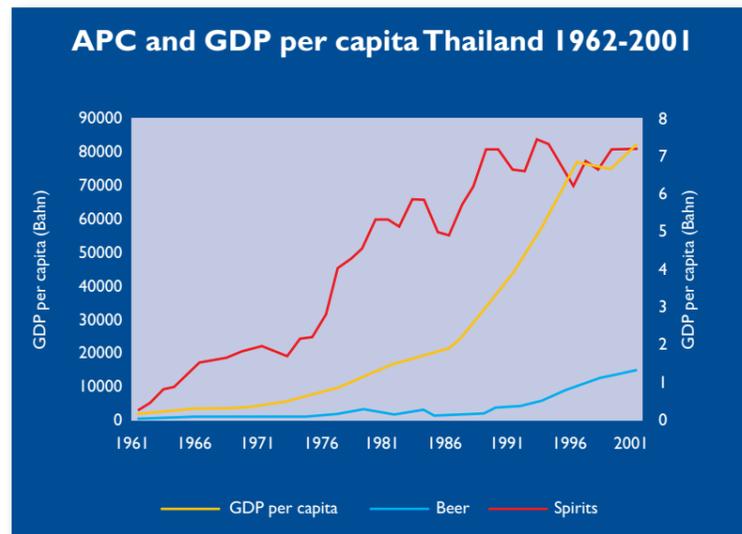
- emergence of wine and beer drinking
- increase in female drinking
- early experimentation and decreasing age of initiation
- shift from urban to rural areas and transitional towns
- more binge drinking
- greater acceptability of drinking as an accepted social norm
- alcohol use along with high risk behaviours

From the study it was estimated that the combined health and socio-economic impact of alcohol outweighs the perceived national economic gain. The cost of alcohol to the Indian community was estimated to be around 244 billion rupees compared with revenue receipts of 216 billion rupees. At an All-India level the question had to be posed "Are we losing more than gaining?"

Dr Girish referred to the impact of the tsunami on alcohol consumption. Immediately after the tsunami, consumption decreased in both male and females. However when relief money was made available, consumption shot up well beyond the level before the tsunami and continued to rise among women.

**The Regional Perspective on Trade, Commerce and Alcohol** was presented by **Thaksaphon Thamarangsi** from **IHPP (International Health Policy Program), Ministry of Public Health, Thailand**.

The relationship between alcohol per capita consumption (APC) and gross domestic product (GDP) per capita in Thailand 1962 – 2001 shows the association of alcohol



### 007: does he work for MI6 anymore?

	Drinks	No. of Films	Frequency per minutes
Sean Connery	36	7	23.1
George Lazenby	7	1	20
Roger Moore	29	7	30.4
Timothy Dalton	10	2	26.3
Pierce Brosman	20	4	25.5
Daniel Craig	12	1	12

consumption to economic well being. The amount of unrecorded consumption varies within the region from about 0.3 to 2.2. litres.

Changes are taking place within the region on supply. New operators and more brands have resulted in creating more competition; increasing cross-border transactions; concentration of investment; mergers and take overs; joint ventures, i.e. brewing contract (especially locally produced international brands); up scaling of domestic producers; more beverage categories - flavoured alcoholic beverages and clearer market segments.

**Dr Yot Teerawattananon, Leader of Health Intervention and Technology Assessment Program, Thailand** illustrated the manner in which the multinational drinks companies exploit film celebrities to spread the western drink culture.

It is known that direct education approaches have met with limited success, but **Dr Adulyanon of the Thai Health Promotion Foundation** in his presentation on 'Interventions on Alcohol in Educational Settings – the Thai Experience' argued that it was important as it underpinned all other interventions. He agreed with Foxcroft *et al* 2003 "Education programmes encourage opinion leaders and policy makers to support structural change."

Thai Health has involved the youth movement as a key actor. Youth's role is perceived as a strength, not as a problem. Youth's role is solving problems and as positive role models in marked contrast to the blame culture so often associated with the portrayal of youth as being the cause of problems.

Mass media and public education campaigns are aimed at raising awareness, reinforcing health related messages, changing perceived norms and "fostering a receptive climate for implementing effective policies" (Howard, *et al* 2007).

Cultural and religion specific approaches are utilised to maximise engagement. An example is the call to stop drinking in Buddhist lent.

Mass media campaigns, including TV ads and newspaper articles, are used to counteract the 'normalisation' of alcohol use – a key feature of the industry's marketing tactics – and to 'de-normalise' the drinking of alcohol through the sponsorship of cultural events and sport.

The Thai Health Foundation has monitored the mobilisation of social networks to support the alcohol control bill and the impact of the campaign to change attitudes.

### Youth movement supporting total alcohol ad ban policy



### Stop drink in Buddhist lent

- 90% of Thai are Buddhist
- Buddhist lent July-October
- Old Buddhist tradition, 'holy period'
- In 2003, 11.8 % Thai people (1.8 m) stop alcohol drinking
- Campaign focused on expanding stop drink tradition nationwide based on this social capital



Mobilizing youth in Thailand

The impact on policy outcomes (a product of effective educational approaches) is noteworthy.

Policy Outcomes

Before the establishment of ThaiHealth and triangle network	After the establishment of ThaiHealth and triangle network
There were 6 national alcohol control policies in 50 years	There are 9 national alcohol control policies in 4 years
National alcohol policies (1950-2002)	National alcohol policies (2003-2007)
Alcohol act 1950	1. Prohibit sale for under 18 (2003)
Limited sale time (1961)	2. Partial ad ban (2003)
Prohibit sale to intoxicated person (1966)	3. Establishing the national alcohol control committee (2003)
Drunk driving (1979)	4. Prohibit sale in school (2004)
Warning message (1997)	5. Warning message in outdoor billboard and movies (2004)
Free trade (1999)	6. Prohibit sale in fuel station (2005)
	7. Increase warning messages (2005)
	8. Increase excise tax (2005)
	9. Alcohol control act (2006-2007)
<b>8 years per 1 policy</b>	<b>2 policies per 1 year</b>

A results-based monitoring and evaluation system has been developed and the communication and social marketing aspects evaluated. 95.2% of respondents agreed with the campaign.

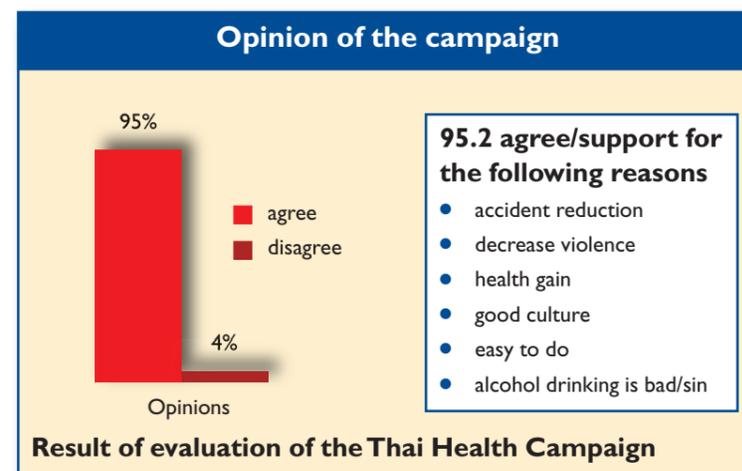
Dr Vijay Chandra, Regional Adviser, Mental Health and Substance Abuse, WHO SEARO, stated that since the 1980's the average age of initiation has reduced from 28 to 20 years of age. Alcohol use is higher in poorer communities. Traditionally alcohol is used by men but use by women is increasing. However, even among men significant proportions are life-time abstainers. Among users, the proportion of dependent users is large. Frequent use of small quantities of alcohol is not the predominant pattern of use as is common in Europe. The number of drinking occasions is fewer, but the amounts consumed at these occasions are large. Issues for concern are: pay-day drinking, violence, including domestic violence, alcohol as a contributor to poverty and illicit and home-brewed alcohol.

Dr Chandra emphasized the need for evidence-based interventions. There was evidence on what works: taxation, restricting availability and accessibility, health promotion, community action - change in social climate, drunk-driving countermeasures, provision of appropriate services for users and restriction of advertising and promotions. What had limited effectiveness were: school programmes based on health harms of alcohol and promoting refusal skills, provision and encouragement of alternate activities, provision of health information related to alcohol through mass media and server training.

Dr Chandra maintained that SEARO initiatives have been successful at many levels: in advocacy, assessment of alcohol use in the community, and in the development of community-based interventions including the use of self-learning material for community volunteers and empowering adolescents.

SEARO's future initiatives would include advocacy with governments and civil society on prevention of harm from alcohol, assessment of use and harm in the community and specifically addressing regional issues.

Other key presentations during the symposium concentrated on the role of the community and of NGOs in promoting alcohol control policies. There were also presentations on the issue of drink-driving and alcohol related enforcement issues and alcohol industry marketing strategies. These themes will be featured in future editions of The Globe, and these presentations will be highlighted at that time. They will provide a valuable contribution to the debate.



Symposium Recommendations

Primary responsibility of WHO (in collaboration with other relevant sectors)

- Information systems and operational research**
  - SEARO should provide technical assistance to Member States to implement community-based assessment of alcohol use (including the socio-cultural factors influencing use), harm from alcohol use and suggestions from the community on prevention of harm from alcohol.
  - WHO (HQ and SEARO) should assist Member States to design a uniform information system for collecting and analysing data that should include:
    - Magnitude of alcohol use, harmful use and dependence
    - Consumption patterns
    - Alcohol problems encountered
    - Alcohol policy options appropriate for the country
  - SEARO should provide technical support to Member States to review the existing literature related to various aspects of alcohol use, based on which country-specific areas for future research can be identified.
- Illegal and home-brewed alcohol**

SEARO should assist Member States in developing a database on illegal and home-brewed alcohol, unrecorded consumption, its impact on the community and how to address related issues. This is a difficult issue to assess and will require an innovative approach which is being developed by the Unit of Mental Health and Substance Abuse.
- Evidence-based interventions**

WHO/HQ and SEARO should facilitate exchange

of experiences of countries at the global level on prevention of harm from alcohol use. Appropriate evidence-based intervention strategies focusing on adolescents and the community should be developed and shared. Technical support in adaptation of these strategies should be provided.

- Cross-border issues**

Regional coordination to address cross-border issues such as impact of trade treaties, advertising and illicit trade in alcohol products should be supported.

Primary responsibility of other sectors (in collaboration with WHO)

- Economic issues**

Relevant agencies (in collaboration with WHO), should strengthen knowledge on taxation mechanisms, and how a percentage of the tax revenue can be utilized to reduce alcohol-related harm. Member States may consider conducting an economic evaluation of the net impact of the revenue gained vs. the economic loss considering the entire spectrum of harm from alcohol use.
- Law and enforcement**

Relevant agencies (in collaboration with WHO), should assist in a review of the existing legislation in Member States with regard to law and enforcement issues related to alcohol, and best practices in addressing illegal alcohol production and control.
- Media**

Relevant agencies (in collaboration with WHO), should provide technical assistance to Member States to monitor media content related to alcohol and its impact on promoting use. Policies and interventions to minimize the adverse impact of portrayal of alcohol in the media should be developed.
- Civil Society**

Relevant agencies (in collaboration with WHO), should work with and provide support for improving technical capacity of NGOs on reducing alcohol-related harm.
- Education sector**

Relevant agencies (in collaboration with WHO) should provide technical support to improve school-based interventions to reduce alcohol-related harm, within a framework of a comprehensive alcohol control policy.

Full report on symposium can be found on SEARO's website: [www.searo.who.int/en/Section1174/Section1199/Section1569.htm](http://www.searo.who.int/en/Section1174/Section1199/Section1569.htm)

# Killer beers

In Cambodia, more than 4,000 'girls' are working as beer promoters in popular entertainment venues. Some are surviving on subsistence wages, many are exposed to extremely unsafe working environments, over half supplement their income with sex work, and around 20 percent have HIV/AIDS. Unsurprisingly, the mortality rate for these women is high and climbing.

Catherine Clark, New Zealand Drug Foundation Policy Analyst reports on the exploitation of young women by multinational beer barons.

Tourists patronising Cambodian bars have no problem finding their favourite beer. In fact, thanks to breweries' marketing tactics, they can be overwhelmed by choice of product.

For the past 10 years international beer giants such as Heineken and Carlsberg have made a fortune from Cambodian entertainment venues, thanks largely to their use of 'beer promotion girls' competing to sell the brands.

They're usually young and attractive women outfitted in skimpy beer branded clothing, competing with others to meet their sales quota. They're good at what they do - in the South East Asia region, the girls bring in over 40 percent of beer sales.

Part of their success lies in drinking on the job, which is common as it is seen as critical to please customers and increase sales. One woman says, "I force myself to drink because if I don't drink with the customers they don't buy my beer." And it isn't just one or two drinks either. A recent study found that the beer girls consumed more than 5 standard drinks per night on average.

Their drinking has direct and harmful effects on the health of these young women. Prevalence of HIV/AIDS is high,

## Killer beers and the brewers

Carlsberg  
Angkor  
Lao Beer  
Holsten  
Heineken  
Gold Crown  
Tiger  
INBEV  
Becks  
Stella Artois  
San Miguel  
Budweiser  
Chang  
Corona  
Guinness  
Singha  
For more information visit

[www.beergirls.org](http://www.beergirls.org)  
[www.fairtradebeer.com](http://www.fairtradebeer.com)



and is often a consequence of sex work. Sometimes the sex is non consensual and, even when it is, safe sex practices are often forgotten or poorly understood.

Harassment in the workplace is also very common, but is regarded as an occupational hazard rather than a violation of human rights. One survey found that 31 percent of women had to seek medical treatment because of violent harassment in the work place.

Health groups have spent years working with these women, focusing on their alcohol consumption and safe sex practices. And they have not been shy in taking on the breweries to achieve social change. Several NGOs and women's rights organisations, have described the companies' marketing tactics as unethical, forced and inhumane, and have accused them of turning a blind eye to the abhorrent working environments of the women.

Attempts have been made to build alliances with breweries and entertainment venue hosts, urging them to take a role in safeguarding the girls who work at their premises.

In 2006, six brewers formed Beer Selling Industry Cambodia (BSIC) and issued a code of conduct which aligned beer promoters' employment status with Cambodian labour law. Previously, beer girls were rarely regarded as employees. Instead they were accounted for in the books as advertising and marketing costs, a scam denying them workers' rights. The code also seeks to protect workers from sexual harassment, to put an end to forced workplace alcohol consumption, and ensure information and education is provided about safe sex. However, the code is silent on fair wages and the provision of financial support for HIV/AIDS treatment - issues the NGOs have included in their own Fair Trade Standard, which they're promoting to all companies.

While improvements have been made, compliance with the code remains disputed by health groups who argue the brewers refuse to promote a safe and healthy workplace for beer girls.

The NGOs routinely expose the breweries' breaches of the code on their campaign websites, where they also publish the experiences of beer girls and an In Memoriam list of women who are dead because of their working environment.

Travelling through South East Asia can be hot and sticky work, no doubt. But while tourists and bar patrons may become thirsty, it's these girls who are literally 'dying for a beer'.

# Call for a Global Strategy

This section of the Globe tracks the progress of the resolution calling for a Global Strategy on Alcohol from the WHO Executive Board Meeting in January 2005; Fifty-Eighth World Health Assembly Resolution in May 2005; the impasse reached at the Sixtieth World Health Assembly on a new resolution; through to the draft and amended resolution discussed at 122nd Session of the WHO Executive Board in January 2008. It also contains a summary of the key findings and recommendations of the WHO Expert Committee 2007; and tables outlining the data on the disease burden attributable to alcohol in 2002.

The Globe has collated the material in this way to provide a full background for alcohol policy advocates concerned over the risks of collaboration between the international public health authority and the alcohol industry.

## Progress of the Resolution

The Globe Editorial (Issue 1 & 2 2007) refers to the difficulties encountered at the World Health Assembly in May 2007, when the process relating to the Global Strategy on Alcohol became stalled in committee. A simple resolution was finally adopted that 'strategies to reduce the harmful use of alcohol and related documents should be included in the agenda of the EB in January 2008 and that the Director General, in the interim, continue her work on this matter'.

Mindful of the difficulty in achieving consensus, and of the emotive and complex nature of the alcohol issue, the New Zealand representative chaired a consensus building meeting on the 3rd December 2007 when agreement was reached on the content and language of a further draft resolution to be presented to the EB in January 2008. Kenya and Rwanda agreed to propose the resolution. (see page 22)

GAPA, on seeing the draft, welcomed its formulation since it represented a balanced and pragmatic approach. GAPA's only concern centred around the wording of paragraph 2(3) in the draft resolution:

*"to collaborate with Member States during the entire process, and actively consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they would contribute to reducing harmful use of alcohol."*

GAPA would have preferred to see a clear distinction between 'consulting with' the economic operators and the other stakeholders named. A possible viable amendment would have been:

- (3) to collaborate with Member States during the entire process, and actively consult with intergovernmental organizations, health professionals and nongovernmental organizations.
- (4) to consult with economic operators on ways they could contribute to reducing harmful use of alcohol;

GAPA considered that the above amendment would have safeguarded the interests of public health in determining alcohol policy, whilst recognising the legitimate involvement of economic operators in the implementation of policy aimed at reducing harm.

However, GAPA representatives observing the EB process were informed that any amendments presented at the EB stage would risk unbalancing the consensus, creating further controversy and causing further delay. GAPA accepted this, believing that any amendments likely to impede progress would be resisted.



**Dr Chan, Director General, in her opening address to the EB at its 122nd Session on the 21st January 2008 commented:** *“You will consider a report on strategies to reduce the harmful use of alcohol. As a starting point for your discussions, this report catalogues the broad range of damage at many levels of health, associated with the harmful use of alcohol. This is a problem we need to take very seriously.”*

On Wednesday 23rd January, ahead of schedule, Rwanda, on behalf of the 46 African countries presented the resolution and other EB members supported. Slovenia (having the Presidency of the European Union) spoke on behalf of the EU endorsing the resolution. Japan expressed support, followed by Iraq on behalf of the EMRO countries.

New Zealand commented that they welcomed further efforts for global action and thanked Rwanda and the African countries for their work on this issue. The USA representative referred to the issue of illicit and unregistered consumption and stated that economic operators needed to be fully engaged as partners in the process. Latvia and Turkey supported the resolution, focusing on the impact of harmful alcohol consumption in their respective societies. China supported the resolution with reference to the need to take measures to tackle the specific circumstances in each country. The language of the resolution was referred to by the Bahamas on behalf of the CARICOM countries. The resolution was well drafted and gave due recognition to the issue of the variation in resources across regions. Sri Lanka in supporting the resolution reiterated the serious problems caused by alcohol and the ‘alcoholisation’ of cultures.

Mexico, having thanked the secretariat of Member States for preparing the draft resolution, felt that it needed to be strengthened and proposed several amendments. Mexico had prepared a pro-industry amendment, paving the way towards not only ‘consultation’ but also ‘collaboration’ with the ‘economic operators.’

**The amended text read:**

*“to collaborate and consult with Member States as well as with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol;”*

Non-Executive Board Members Cuba, Russia and Chile supported the resolution. Cuba in particular had given careful attention to the debate and thanked

those who had drafted the resolution. Chile went on to support Mexico’s amendment and Cuba also came in to support the amendment proposed by Mexico.

Rwanda expressed gratitude for those who expressed support for the resolution and indicated that Mexico’s amendments would be acceptable. Slovenia on behalf of the EU also accepted the amendment. New Zealand, whilst supporting the amendment, struck a note of caution stating that further amendments could potentially create problems for the progress of the issue.

On behalf of the Secretariat, the Assistant Director General (Non-Communicable Diseases and Mental Health) responded to some of the issues that had been raised and, with particular reference to the comments of the USA delegate, stated that there was an ongoing consultative process with the beverage alcohol industry and that the next consultation meeting with them was scheduled for 21st February 2008.

**Globe comment:** Despite the fact that the amendments were tabled ‘late in the day’ and the EB was ahead of schedule, no member asked for an adjournment until the next day in order to reflect on the consequences of the amendment. An amendment that, in our opinion, substantially altered the tenor of the previously worded agreed draft. It left one with the belief that pre-agreement had been negotiated in the ‘corridors’.

# WHO Expert Committee Report on Problems Related to Alcohol Consumption 2007

## Summary of key findings and recommendations

In its introduction to the report the Expert Committee draws attention to both its 1979 Report and the 1998 World Health Declaration.

The 1979 Report recognised the wide diversity of the medical and social ills and human suffering resulting from alcohol consumption; the limited efficacy and high cost of existing treatment or management of problems; and the high prevalence of alcohol problems in the world. It recommended that prevention be given clear priority and the development of inexpensive and cost effective treatment. The report noted that damage from alcohol was closely related to the level of consumption of both individuals and population. It recommended that governments should begin to reduce consumption by reducing availability; take educational and other measures to reduce demand; adopt national alcohol policies; bring the serious public health consequences and the high social and economic costs of alcohol consumption to the attention of national, regional and international authorities when alcohol trade policies are being reviewed and negotiated.

The 1998 World Health Declaration reaffirmed WHO’s commitment to the principle that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; the improvement of the health and well being of people is the ultimate aim of social and economic development and the importance of reducing social and economic inequalities in improving the health of the whole population.

## Terminology

In its present report the Committee considers as equivalent terms *“alcohol-related harm”* and *“problems related to alcohol consumption”*. They refer to a wide range of social and health problems both to drinkers and others at individual and collective levels. The term *“harmful use of alcohol”* is included in the aforementioned terms since it refers to a condition where an individual has experienced physical or psychological harm from his or her drinking. In a public health perspective it has a wider meaning in the broader understanding of health and in the harm caused to others. In its frame of reference the Committee adopted the whole range of harms related to alcohol consumption and the policies and measures that would reduce such problems and harms.

## Types of harm

The Committee recognises that the use of *“alcoholic beverages carries with it some potential for social and health harm, both to the drinker and others”*. The three main mechanisms of harm are intoxication, dependence and toxicity.

Alcohol is related to more than 60 different disorders, among which are: breast cancer among women with no evidence of a threshold and an increasing risk with increasing consumption; a potent teratogen –foetal alcohol syndrome; an impact on brain development by exerting an effect at the cellular and molecular levels – the report states *“adolescents and*



young people are particularly vulnerable to the harmful effects of alcohol. It can particularly affect the part of the brain involved in the learning process – the hippocampus; liver damage; carcinogenic; adverse immunological consequences leading to increased incidence of infectious diseases.

With regard to heart disease the report recognises that the effects of alcohol are both positive and negative. For regular light drinkers as little as a drink every other day appears to have a preventive effect. Although the report cautions: “the finding remains controversial and appears to be confined to males over the age of 45 years and females post menopause. However heavy drinking levels are associated with increased rates of heart attacks. Even in societies where heart disease is a very important cause of death, the overall number of lost years of life attributable to drinking outweighs the saved years attributed to protective effects”.

Alcohol's toxic effects can harm any system or organ of the body; exacerbate pre-existing mental and physical disorders; adversely interact with other prescribed and illicit drugs; be associated with a wide range of intentional and unintentional injuries; and produce a dependence syndrome with an abuse liability comparable to other dependence producing substances that are internationally controlled.

Based on data available for 2002 the Committee reviewed the overall net impact on the burden of disease (see tables 1,2 and 3).Alcohol is estimated to cause 3.7% of all deaths and 4.4% of the global burden of disease. This is after the health protective effects were taken into account. It is acknowledged that a wide variety of adverse consequences of drinking are not covered in the estimates such as adverse consequences for persons other than the drinker, lack of data in relation to communicable diseases and the consequences of social harm.

Although substantial progress has been made in estimating global health harm, the Committee recognised the need for further development in four priority areas:

- i) the development of measurements of alcohol's role in social harms;
- ii) the measurements of harms from drinking to third parties;
- iii) epidemiological studies of alcohol's contribution to infectious disease morbidity and mortality and
- iv) implementation of a routine basis in health emergency service of measurements of alcohol involvement in injuries.

### Abstinence and Indigenous groups

Less than one half of the world's adult population (2 billion people) use alcohol. Abstention rates are higher among females (66%) than among males (45%). If abstention rates decline with increasing affluence and exposure to global marketing, substantial rises can be expected in levels of consumption. The Committee expressed the view that there is “an important public health interest in encouraging abstinence and protecting the choice to abstain”.

Studies of indigenous peoples show significantly higher alcohol intake than in the surrounding general population although rates of abstention are often higher. However, among indigenous populations patterns of drinking tend to be more hazardous. Poor living and working conditions together with increased access and availability of commercial alcohol, lack of education, health and treatment services has led to a high morbidity and mortality from alcohol related causes in indigenous communities. The Committee noted the success of some indigenous communities to reduce alcohol problems and commented, “These efforts often involve persuading the enveloping society to set aside usual market freedoms, and allow the community to restrict promotion and availability of alcoholic beverages”.

### Impact on the Poor

Poor people suffered a disproportionate burden of harm. Their lack of resources show them less able than the affluent to purchase social or spatial buffering of their behaviour. The Committee states: “Public health action to reduce drinking and associated harm also serves the interest of reducing health disparities between richer and poorer individuals and populations.”

### Effective Strategies to Reduce Alcohol Related Harm

Since the previous report the Committee recognises that there has been accumulated a substantial literature on the impact of various alcoholic policies and measures. Whilst cost effective studies are not well enough established as a reliable guide, the Committee took the effectiveness of the evidence as its primary guide. It also maintained that whilst the effectiveness of policies had been evaluated in the context of high-income countries, some measures

had been evaluated in the context of low income countries.

The Committee sets out the strategies available to reduce alcohol related harm which are well known to alcohol policy advocates: tax and price; control of availability; restrictions on sale; drinking context and marketing; drink driving and early intervention strategies. Some pertinent findings of the review are:

**Price.** Limited data from low and middle -income countries show a similar pattern in the relationship

between price and consumption as in high –income countries. Increasing alcohol taxes can be used to reduce consumption and harm, whilst at the same time increasing government income. Young people's consumption is sensitive to tax. The amount heavy drinkers consume is affected by price. Lowering alcohol taxes and prices leads to increased consumption. In Europe special taxes on spirit based sweet pre mixed drinks (alcopops) has led to a reduction in sales. Alcohol taxes are a highly cost effective strategy for reducing alcohol related harm.

## Summary of WHO data on disease burden attributable to alcohol in 2002

Table A1.1

Deaths attributable to alcohol consumption in the world in 2002

Disease category	Number of deaths (thousands)			Percentage of deaths as a proportion of the deaths attributable to the disease categories listed		
	Males	Females	Total	Males	Females	Total
<b>Deaths caused</b>						
Maternal and perinatal conditions (low birth weight)	1	1	3	0.1	0.3	0.1
Cancer	361	105	466	18.7	25.0	19.8
Diabetes mellitus	0	1	1	0	0.2	0
Neuropsychiatric disorders	106	25	130	5.5	5.9	5.5
Cardiovascular diseases	452	77	528	23.3	18.2	22.4
Cirrhosis of the liver	293	77	370	15.2	18.2	15.7
Unintentional injuries	501	96	597	25.9	22.7	25.3
Intentional injuries	220	40	260	11.4	9.6	11.1
Total 'detrimental effects' attributable to alcohol	1,934	421	2,355	100.0	100.0	100.0
<b>Deaths prevented</b>						
Diabetes mellitus	-8	-5	-12	7.7	3.5	5.3
Cardiovascular diseases	-90	-130	-220	92.3	96.5	94.7
Total 'beneficial effects' attributable to alcohol	-98	-135	-232	100.0	100.0	100.0
<b>All alcohol-attributable net deaths</b>	<b>1,836</b>	<b>287</b>	<b>2,123</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
All deaths	29,891	27,138	57,029			
Net deaths attributable to alcohol as a percentage of all deaths	6.1%	1.1%	3.7%			



**Advertising.** Recent research has shown that where young people are exposed in markets to a greater availability of advertising - exposure appears cumulative - and young people are more likely to increase their drinking as they moved into their mid twenties. Drinking declined earlier in those who were less exposed.

Reliance on self- regulation does not prevent the kind of marketing which has an impact on young people.

*“Unless industry processes related to alcohol advertising standards come under a legal framework, and are monitored and reviewed by a government agency, governments may find that allowing self regulation by the industry results in a loss of policy control of the marketing of a product that seriously affects public health”.*

**Drink Driving measures.** Establishing a maximum blood alcohol concentration and random breath testing has proved to be most effective. Adoption of

such measures has also strengthened the public will. In low income countries injuries to intoxicated pedestrians are more common than driver and passenger injuries.

**Early Intervention.** People who drink alcohol excessively place a disproportionate burden on health social and criminal justice systems compared with light drinkers or abstainers. Also a disproportionate amount of the intangible cost of excessive drinking on families and the workplace. Such intervention the committee feels has potential to fulfil three goals i) humanitarian approach to alleviation of human suffering ii) a method of reducing alcohol consumption and harm in the population and iii) reducing alcohol related health care costs. For people with more severe alcohol dependence they will require more intensive approaches.

**Education.** Although there is evidence, in relation to school based programmes, of positive effects on increased knowledge about alcohol, no evidence has been found for a sustained effect on behaviour. Public information campaigns are an ‘ineffective antidote to the high quality pro drinking messages that appear far more frequently in the media’ There has been no evidence of whether drinking guidelines have any impact on alcohol related harm.

**Considering the effects of alcohol marketing measures on young people, the committee recommends that WHO supports and assists 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 enforcing 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.

**Within the context of a public health approach to alcohol related problems, the committee recommends that WHO support governmental bodies at national and sub-**

**national levels, and in particular in low-and middle-income countries:**

- to give high priority to the prevention of harmful use of alcohol, with an increased investment in the implementation of policies known to be effective;
- to continue to review the nature and extent of the problems caused by the harmful use of alcohol in their populations, the resources and infrastructures already available producing the incidence , prevalence and impact of these problems, and the possible constraints in establishing new policies and programmes;
- to formulate, develop and implement adequately financed action plans on alcohol with clear objectives, strategies and targets
- to establish or reinforce mechanisms and focal points to co-ordinate the work of public health stakeholders;
- to implement and evaluate evidence-based policies and programmes using existing structures where feasible.

### Investment in Young People

The importance of investment in young people for socioeconomic development is recognised by the committee. The determinants of harmful drinking among young people and increasing the human capital of young people should be addressed. The increasing promotion of alcoholic beverages in culture and the arts particularly the massive investment of product placement in movies, television, music and videos is an international issue with public health significance for UNESCO action.

### Sectors and Alcohol Policy

The Committee recognised that the alcohol industry has become increasingly involved in the alcohol policy area particularly through the funding of an international, regional and national network of social aspect organizations that sponsored industry friendly policies. The Committee expressed a note of caution that the “private sector should not be trying to do the work of governments which are particular guardians of the public interest”. The alcohol industry had a role in the implementation of programmes to provide server training, ensuring responsibility in adhering to the law in reducing hazardous drinking and preventing under age drinking.

## Summary of WHO data on disease burden attributable to alcohol in 2002

Table A1.2

Disability-adjusted life years (DALYs) attributable to alcohol consumption in the world in 2002

Disease category	Number of DALYs (thousands)			Percentage of DALYs as a proportion of the DALYs attributable to the disease categories listed		
	Males	Females	Total	Males	Females	Total
<b>Deaths caused</b>						
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	100.0	100.0	100.0
<b>Deaths prevented</b>						
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
<b>All alcohol-attributable net deaths</b>	<b>54,970</b>	<b>10,006</b>	<b>64,975</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
All deaths	772,912	717,213	1,490,126			
Net deaths attributable to alcohol as a percentage of all deaths	7.1%	1.4%	4.4%			



**The Committee recommends that:**  
*“WHO continue its practice of no collaboration with 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 role as producers, distributors and marketers of alcohol, and not in terms of alcohol policy development or health promotion.”*

**Public health and health care workers** have a leading role in reducing harm by integrating assessment and interventions on harmful drinking into health care systems and by informed advocacy for alcohol policies. They should be a catalyst for change and recognise the significance of mass media coverage on agenda setting for policy makers.

**Non Governmental Organizations** have an important role in the development of alcohol policy and action. The Committee emphasised: *“the importance of the participation of civil society organisations without conflict of interests in alcohol policy development, as a counter- influence to the vested interests, which might otherwise dominate political decision making.”*

**The Expert Committee recommends that “WHO strengthen its process of consultation and collaboration with nongovernmental organizations which are free of potential conflict of interest with the public health interest.”**

Reaffirming resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse, WHA55.10 on mental health: responding to the call for action, WHA57.10 on road safety and health, WHA57.16 on health promotion and healthy lifestyles and WHA57.17 on the Global Strategy on Diet, Physical Activity and Health;

Recalling The World Health Report 2002,<sup>1</sup> which indicated that 4% of the burden of disease and 3.2% of all deaths globally are attributed to alcohol, and that alcohol is the foremost risk to health in low-mortality developing countries and the third in developed countries;

Recognizing that the patterns, context and overall level of alcohol consumption influence the health of the population as a whole, and that 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;

Emphasizing the risk of harm due to alcohol consumption, particularly, in the context of driving a vehicle, at the workplace and during pregnancy;

Alarmed by the extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people, in many Member States;

Recognizing that intoxication with alcohol is associated with high-risk behaviours, including the use of other psychoactive substances and unsafe sex;

Concerned about the economic loss to society resulting from harmful alcohol consumption, including costs to the health services, social welfare and criminal justice systems, lost productivity and reduced economic development;

Recognizing the threats posed to public health by the factors that have given rise to increasing availability and accessibility of alcoholic beverages in some Member States;

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Noting the growing body of evidence of the effectiveness of strategies and measures aimed at reducing alcohol related harm;

Mindful that individuals should be empowered to make positive, lifechanging decisions for themselves on matters such as consumption of alcohol;

Taking due consideration of the religious and cultural sensitivities of a considerable number of Member States with regard to consumption of

alcohol, and emphasizing that use of the word “harmful” in this resolution refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way,

1. The World Health Report 2002. Reducing risks, promoting healthy life. Geneva, World Health Organization, 2002.

- 1. REQUESTS Member States:**
  - 1 to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol;
  - 2 to encourage mobilization and active and appropriate engagement of all concerned social and economic groups, including scientific, professional, nongovernmental and voluntary bodies, the private sector, civil society and industry associations, in reducing harmful use of alcohol;
  - 3 to support the work requested of the Director-General below, including, if necessary, through voluntary contributions by interested Member States;
- 2. REQUESTS the Director-General:**
  - 1 to strengthen the Secretariat’s capacity to provide support to Member States in monitoring alcohol-related harm and to reinforce the scientific and empirical evidence of effectiveness of policies;
  - 2 to consider intensifying international cooperation in reducing public health problems caused by the harmful use of alcohol and to mobilize the necessary support at global and regional levels;
  - 3 to consider also conducting further scientific studies pertaining to different aspects of possible impact of alcohol consumption on public health;
  - 4 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;
  - 5 to draw up recommendations for effective policies and interventions to reduce alcohol-related harm and to develop technical tools that will support Member States in implementing and evaluating recommended strategies and programmes;
  - 6 to strengthen global and regional information systems through further collection and analysis of data on alcohol consumption and its health and social consequences, providing technical support to Member States and promoting research where such data are not available;
  - 7 to promote and support global and regional activities aimed at identifying and managing alcohol use disorders in health-care settings and enhancing the capacity of health-care professionals to address problems of their patients associated with harmful patterns of alcohol consumption;
  - 8 to collaborate with Member States, intergovernmental organizations, health professionals, nongovernmental organizations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption;
  - 9 to organize open consultations with representatives of industry and agriculture and trade sectors of alcoholic beverages in order to limit the health impact of harmful alcohol consumption;
  - 10 to report through the Executive Board to the Sixtieth World Health Assembly on progress made in implementation of this resolution.

### Summary of WHO data on disease burden attributable to alcohol in 2002

Table A I.3

Percentage of all deaths attributable to alcohol consumption in 2000 and 2002 in WHO regions

WHO region	Males (%)		Females (%)		Total (%)	
	2000	2002	2000	2002	2000	2002
African Region	3.3	3.4	0.9	1.0	2.1	2.2
Region of the Americas	2.3	8.7	0.8	1.7	4.8	5.4
South-East Asia Region	2.6	3.7	0.4	0.4	1.6	2.1
European Region	10.2	10.8	0.6	1.7	5.5	6.4
Eastern Mediterranean Region	0.6	0.8	0.1	0.1	0.4	0.5
Western Pacific Region	8.0	8.5	0.7	1.5	4.5	5.2
World	5.6	6.1	0.6	1.1	3.2	3.7

Source: WHO



*We have set side by side the draft and approved resolutions and marked in red the amendments made.*

The Executive Board,  
Having considered the report on strategies to reduce the harmful use of alcohol<sup>1</sup>,  
RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,  
Having considered the report on strategies to reduce the harmful use of alcohol and noting that the report contains further guidance on strategies and policy element option to reduce harmful use of alcohol;

Reaffirming resolutions WHA32.40<sup>2</sup>, WHA36.12<sup>3</sup>, WHA42.20<sup>4</sup> and WHA57.16<sup>5</sup>;

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

Noting the report by the Secretariat presented to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public health problems caused by harmful use of alcohol<sup>6</sup>;

Noting the second report of the WHO Expert Committee on Problems Related to Alcohol Consumption<sup>7</sup> and acknowledging that effective strategies and interventions that target **both the population at large**, vulnerable groups, individuals and specific problems are available and should be optimally combined in order to reduce alcohol-related harm;

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

Deeply concerned by the extent of public health problems associated with harmful use of alcohol, including injuries and violence,

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and possible links to certain communicable diseases **which add** to the disease burden, **notably in the developing world;**

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

- 1 Documents EB122/10 and EB122/10 Corr.1.
- 2 Development of the WHO programme on alcohol-related problems.
- 3 Alcohol consumption and alcohol-related problems: development of national policies and programmes.
- 4 Prevention and control of drug and alcohol use.
- 5 Health promotion and healthy lifestyles
- 6 Documents A40/14 and A60/14 Add.1.
- 7 WHO Technical Report Series, No. 944, 2007

### I. URGES Member States:

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

### 2. REQUESTS the Director-General:

- (1) to develop a draft global strategy to reduce harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options, taking into account different national, religious and cultural contexts, including national public health problems, needs and priorities, as well as differences in Member State resources, capacities and capabilities;
- (2) **to comprehensively include** ongoing and emerging regional, subregional and national processes as vital contributions to a global strategy;
- (3) **to collaborate with Member States during the entire process, and actively consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol;**
- (5) to present to the Sixty-third World Health Assembly a draft global strategy to reduce harmful use of alcohol, through the Executive Board.

The Executive Board,  
Having considered the report on strategies to reduce the harmful use of alcohol<sup>1</sup>,  
RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,  
Having considered the report on strategies to reduce the harmful use of alcohol and the further guidance on strategies and policy element options therein;

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

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

Noting the report by the Secretariat presented to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public health problems caused by harmful use of alcohol<sup>2</sup>;

Noting the second report of the WHO Expert Committee on Problems Related to Alcohol Consumption<sup>3</sup> and acknowledging that effective strategies and interventions that target the **general population**, vulnerable groups, individuals and specific problems are available and should be optimally combined in order to reduce alcohol-related harm;

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

Deeply concerned by the extent of public health problems associated with harmful use of alcohol, including injuries and violence,

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and possible links to certain communicable diseases, **thereby adding** to the disease burden, **in both developing and developed countries;**

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

- 1 Documents EB122/10 and EB122/10 Corr.1.
- 2 Documents A60/14 and A60/14 Add.1
- 3 WHO Technical Report Series, No.944, 2007.

### I. URGES Member States:

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

### 2. REQUESTS the Director-General:

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





“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 Arulraj, India  
 Mr Ross Bell, New Zealand  
 Mr Sven Olov Carlsson, Sweden  
 Dr Michel Craplet, France  
 Mr George Hacker, USA  
 Dr David Jernigan, USA  
 Dr Ronaldo Laranjeira, Brazil  
 Dr Shanti Ranganathan, India  
 Dr Srisangnam Udomsilp, Thailand  
 Mrs Pamodinee Wijayanayake, Sri Lanka  
 Dr Richard Yoast, USA

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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.

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.

# About smoke and mirrors: the alcohol industry and the promotion of science

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Available in print only,  
 Globe Magazine 3,2007 &  
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# Alcohol – a great public health harm Commonwealth Medical Association

Dr S Arulraj

President Commonwealth Medical Association (CMA)  
Chairman Indian Alcohol Policy Alliance (IAPA)

GAPA warmly welcomes and salutes the installation of Dr S Arulraj as CMA President for the next three years.

Also Chairman of IAPA and former President of the Indian Medical Association. Dr Arulraj has made tackling public health problems related to alcohol as one of his top priorities during his triennium. GAPA colleagues have assured him of their support and commend his commitment to this challenging public health issue.

The installation ceremony took place during the joint CIMA and CGP 007 Conference in Chennai, 24th and 25th November 2007. In a well-attended meeting Professor A.B. Akosa, handed over the Presidency and felicitations were delivered by Smt Radhika Selis (Honorary Union Minister of State for Home Affairs) and Smt Geetha Jeevan (Honorary Minister for Animal Husbandry).

As incoming President, Dr Arulraj was praised for his dedicated service to medicine and for his many acts of philanthropy.

In his Presidential address, following greetings, Dr Arulraj said that it was “a proud moment for me to stand before you as the President, CMA. At this juncture I remember the support extended by our National President, IMA, Dr Ajay Kumar and past National Presidents, Dr Ketan Desai, Dr P V George and Dr Sudipto Roy to bring this honour to India”.

48 out of the 53 Commonwealth countries are members of CMA, and Dr Arulraj will be supported by a strong team of Regional Vice Presidents and by CMA Secretary, Dr Oheneba Owusu-Danso from Ghana.

Under the theme of Healthcare, the President makes a strong call for action on Alcohol. Both the American Medical Association and the World Medical Association have sent strong recommendations to WHO. Equally the CMA has supported the stand of WHO to develop a Global Strategy on Alcohol. The

CMA will call on Governments to take action to limit the health consequences of alcohol.

“Many views are aired that alcohol is good for Health if taken within limits. Limit is the issue for human beings everywhere. Alcohol related diseases are on the increase; one in six hospital beds are occupied by Alcohol Related Diseases, one in three Emergency Bed is occupied by RTA victims suffered by Drink Driving. The mortality and morbidity rate is higher than that of Heart Attacks and HIV/AIDS. It is a **hidden killer** which is surfacing very badly.

**“I appeal to National Medical Associations to highlight the Public Health Harms of Alcohol to their Government and to their Society.”**  
**Dr Arulraj, President CMA**



“The Medical Profession is in a unique and influential position to safeguard the health and well being of individuals and to advocate implementation of alcohol control policies that work. Together we must face the challenges of this global culture of intoxication. We have to build up the human capital in youth, lest, as the World Development Report of the World Bank (2007) warns – ‘missed opportunities to invest in and prepare this generation will be extremely costly to reverse both for young people and society.’”

## Training

Dr Arulraj also announced the establishment of a CMA Trust to support poorer countries in developing their Medical Education, Training and Healthcare Strategies.

Twinning arrangements between countries will also facilitate Medical Education and Healthcare across the divide so that “all Commonwealth Nations will be Developed Nations in Health.” Collaborating with the CMA in the training of the Medical profession in alcohol issues and interventions will be a priority for GAPA, and we look forward to the achievement of this ambitious triennium goal.

Mr Derek Rutherford, Chairman, GAPA, presented a lecture during the Scientific Programme of the Conference in place of Professor Brian Prichard, CBE, who was attending a seminar on alcohol harm with the British Prime Minister at Downing Street.

In his closing remarks, Derek Rutherford encouraged CMA members to work together to meet the challenge of the ‘**global culture of intoxication**’.



Members of the IAPA at their board meeting in Chennai

# Alcohol, Gender, Culture and Harms in the Americas and a Case For Action

Pan American Health Organization (PAHO)

World Health Organization (WHO)

The PAHO Multicentric Study Final Report was published in 2007 (ISBN 978 92 75 128282). The project was coordinated by Dr Maristela G Monteiro, Regional Advisor on Alcohol and Substance Abuse at PAHO in collaboration with Professor Dr Jurgen Rehm from the Centre for Addiction and Mental Health, Canada. Benjamin Taylor was the leading author of the report.

The investigators and their teams from Argentina, Belize, Brazil, Canada, Costa Rica, Mexico, Nicaragua, Peru, Uruguay and the USA participated in the planning, implementation, analysis and dissemination of the data. The project received a grant from the PAHO program on Information and Knowledge Management as well as from other WHO sources and a voluntary contribution for CAMH.

**“This new survey data highlights the importance of disaggregating sub-regional WHO data to the country level in order to see differences in consumption and corresponding risk of alcohol-attributable outcomes at the country level and thus inform country-specific alcohol policies capable of addressing the specific alcohol consumption profiles and problems.”**

**Executive Summary  
PAHO Multicentric Study  
Final Report**

The Report contains a detailed overview of the regional data and its relationships to mortality and morbidity in the Americas. The relative risk estimates are considered to be “the most current and best possible for the individual countries and the region, and should be extremely valuable for informing alcohol policy accordingly”.

**Summary of main results from this limited preliminary analysis and discussions points:**

- Overall consumption in the Americas is high compared to global averages.
- Alcohol consumption and the prevalence of dangerous drinking behaviour (heavy episodic drinking) are high among young men and women in all countries in the Americas.
- The alcohol-attributable burden of disease of young adults is especially high, particularly in America B and D.
- The alcohol-attributable burden for young people, both men and women, is high.
- Neuropsychiatric diseases constitute a major proportion of years of life lost and disability adjusted life-years.

Practices to reduce per capita consumption (Babor et al., 2003; Anderson & Baumberg, 2006) should apply to the Americas, such as taxation and availability restrictions. These availability restrictions include measures to increase the minimum age to drink alcohol, alcohol retail outlet density and hours of operation, availability at sporting events, and minimizing alcohol advertisements and marketing (Anderson & Baumberg, 2006; Rehm et al., 2004; Babor et al., 2003; Giesbrecht & Greenfield, 2003). With respect to taxation, there is clear evidence that consumers react to prices for goods including alcohol. Newer economic literature found this behaviour even in people with alcohol dependence (see chapter 6 in Babor et al. 2003). Given the relatively low tax rate in most of the American countries (especially in South and Central America) and given the high

consumption of countries such as Canada, Belize, and Brazil, an increase of the taxation of alcoholic beverages should be a priority for alcohol policy in this region given its effect on consumption and its cost-effectiveness (Chisholm et al., 2004; 2006).

The second and third major findings of this brief analysis found that young people consume much of the alcohol, consume it in a more dangerous way, and more often suffer two alcohol-related acute outcomes (injury and fighting) than older age cohorts. Given this consumption behaviour, the alcohol-attributable burden of disease for acute outcomes is especially high.

A number of policy options are particularly effective in reducing the alcohol consumption in this group, such as price increases and raising the age at which young people can legally purchase liquor in, on- and off-licence establishments (Babor et al., 2003). Enforcement of such minimum drinking age laws in developing and developed countries alike is a limitation of this approach that needs to be taken account of for such measures to be effective (Giesbrecht & Greenfield, 2003).

Neuropsychiatric diseases constitute a major proportion of the alcohol-attributable burden. Within this category, alcohol use disorders make up the highest proportion of this category (Rehm & Monteiro 2005), especially in Americas B and D. The use of the screening and brief interventions in primary health care to increase referral to treatment services, along with the organization of an integrated health system, provides effective treatment for alcohol dependence and harmful use of alcohol (Babor et al. 2001). Self-help groups such as AA and social services should be linked to treatment services to support recovery and rehabilitation. There are a number of effective treatments for alcohol dependence, including cognitive behaviour therapies (Marques & Formigoni 2001; Morgenstern et al. 2001; Hoyer et al. 2001), brief intervention/counselling (Mundt

2006), and pharmacotherapy (Chick et al. 2000), and combinations of these together (Anton et al. 1999), which can be offered through various outpatient or inpatient services. (pages 42 and 43)

This project is rightly described as a ‘landmark endeavour’ and will undoubtedly form the cornerstone for future regional and national actions.

In terms of global responses the report calls for further evaluation of policy in ‘**developing nations, across races, and within cultures**’ (p 44) a call that will resonate with GAPA.

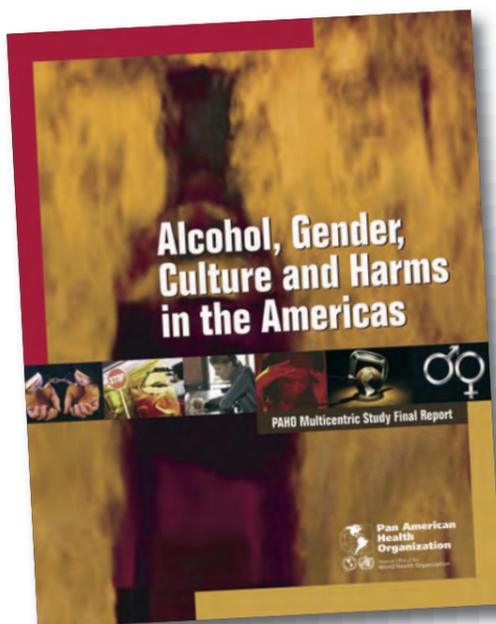
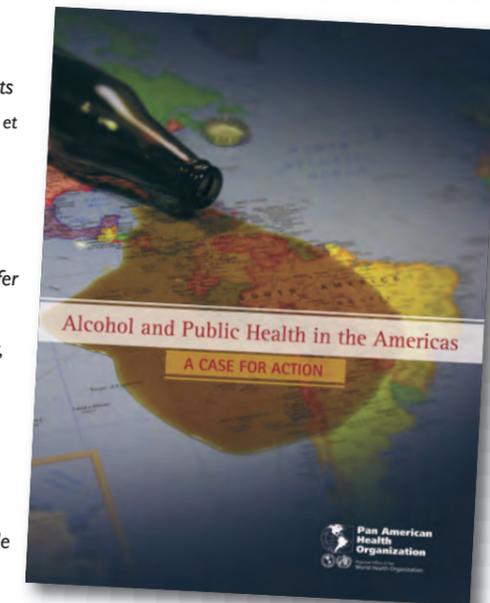
Another landmark publication - ‘**Case for Action**’ on ‘**Alcohol and Public Health in the Americas**’

(PAHO 2007) captures the essence of the actions required to reduce alcohol-related harm.

Based on the latest reviews (Babor et al. 2003 and WHO Expert Committee WHA A60/142007), chapter 5 sets out “**10 Building Blocks to Reduce Alcohol Related Harm**” recognising at the same time the on going challenges facing policy makers and those who have the task of implementing policy.

One of the greatest challenges to effective implementation is the relentless expansion of the global market. Over 50% of the global market of alcoholic beverages is now under the control of the top 10 global producers and international trade agreements continue to classify alcohol as an ‘ordinary’ commodity.

The ‘Case for Action’ states that the enforcement of trade agreements by the World Trade Organization “has led to a weakening of public health-based alcohol controls in developed and developing nations” (Caetano and Laranjeiras, 2006; Monteiro and Levay, 2006) and that “**Health professionals and policy makers need to become more involved in trade policy formulation and to determine how current trade rules affect not only the present but also the future of health**” (p 33).



# GAPA Chairman visits Thailand

Report by Nattika Changprasert  
International Project Assistant, StopDrink Network

During 26th – 28th November 2007, Mr Derek Rutherford, the Globe Editor in Chief and Chair of the Global Alcohol Policy Alliance (GAPA), visited Thailand with Mr Aneurin Owen.

During his visit, Derek Rutherford took the opportunity to present a letter supporting the Thai Alcohol Control Bill addressed to Dr Meechai Ruchupan, the Chairperson of the National Legislative Assembly (NLA) and given to Ms Uma Sukontama, NLA Member, at the Parliament on 27 November 2007. In addition, Mr Rutherford and Mr Owen had a chance to share their views on global alcohol control policy with some other NLA Members such as Mr Krayim Santrakul, General Parnthep Bhuwanarchnurak, and Mr Somchai Sawaengkarn.

During the discussion, Mr Rutherford said that GAPA has been monitoring the growing epidemic of problems associated with alcohol intoxication and dependence worldwide, particularly in the Asian region

which has become a strategic market for the alcohol industry. The rising trend in alcohol consumption especially in the younger generation needs appropriate action and political courage to ameliorate these problems. He further stated that the World Bank Development Report 2007 is concerned that young people are exposed to a greater range of health risks than before due to the growth of non-communicable diseases.

Mr Rutherford said encouragingly, “We acknowledge Thailand’s past leadership in alcohol control policy and offer our congratulations on your willingness to take a further step to strengthen your policy advocacy toward legislation on alcohol control. In this perspective, Thailand’s proactive leadership on



such an important law is not only a good example for other countries in the region, but it will add to the international respect your country has already earned in this field”.

Besides meeting with NLA Members, the GAPA representatives joined the StopDrink Network meeting, whose objective was to prepare and organise the demonstration emboldening the NLA to pass the alcohol control bill on the following day (28 November 2007). They admired the Network’s contribution on pushing forward alcohol control policy to protect Thai society, especially the younger generation, from the harms of alcohol.

On the day when the NLA considered the alcohol control bill in the final round, Mr Rutherford and Mr Owen observed the demonstration in front of the parliament, where the crowd expressed their views and youth groups gave performances illustrating why the alcohol control bill is necessary. Both of the observers were impressed by the power of the demonstrating group and suggested that this magnificent rally should be repeated in other parts of the world to stop the global march to a culture of alcohol intoxication.

The demonstrating group were however disappointed by ensuing events. The parliamentary result on the

**Above L to R:** Derek Rutherford, Mr Somchai Sawaengkarn (NLA Member), Ms Areekul (Kung) Puangsuwan (The Project Manager of The International Collaborating Center of the StopDrink Network) and Aneurin Owen.

**Opposite:** Derek Rutherford at the demonstration in front of the Parliament.

alcohol control bill disappointed the crowd and supporting Thais because of the amendment on the alcohol advertisement ban under section 31, which allows alcoholic beverages to be broadcast if there is no picture of an alcohol container shown in the advertisement, except for the symbol of that beverage and company.

The Minister of Public Health, Dr Mongkol Na Songkhla, seeing this amendment, withdrew the bill from the NLA with the expectation that the bill would be reviewed and resubmitted to the NLA before the general election.

On 21 December, the last NLA meeting of the interim government, the draft legislation was resubmitted to the NLA in order to be reviewed in the second and third rounds, and it eventually received approval from the NLA. However, sections 31/1-34 covering various advertisement issues were removed. The items omitted included the advertisement ban on radio and television, in theatres, advertisements in print media and on billboards, sponsorship, use of alcohol logos on non-alcoholic beverages and the use of the name companies on advertisement. However the Ministry of Public Health will be able to draft a ministerial regulation for such controls at a later date.

# Alcohol – price, policy and public health

Report on the findings of the Expert Workshop on Price

Convened by Scottish Health Action on Alcohol Problems (SHAAP)

December 2007

SHAAP is to be commended for producing this timely Report. It coincides with other calls on Central and Devolved Governments to take action now to prevent the rise in alcohol-related harm.<sup>1</sup> This Report contains seven key Recommendations, two of which call on the Scottish Government to make representation to Westminster to:

- **increase alcohol duty and link alcohol taxes to inflation (Recommendation 3)<sup>2</sup>**

and to

- **link levels of taxation to alcohol strength (Recommendation 4)<sup>3</sup>**

On licensing, the Report highlights one of the fundamental differences between current Scottish and English approaches to alcohol policies referred to in Section Four (p. 43)

*“In Scotland, a public health principle has been enshrined in the new licensing legislation which comes into force in 2009. This places a duty on local licensing boards to consider the protection and improvement of public health when granting or reviewing licences. The new legislation also prohibits irresponsible drinks promotion in pubs, clubs and restaurants (the on trade sector), meaning that ‘happy hours’, ‘all you can drink’ offers in return for a club entry fee, and other similar promotions, will be outlawed. More recently, the Scottish government has published regulations which, if implemented will require retailers to have separate display areas for alcohol.”*

**(Draft Licensing (Mandatory Conditions No. 2) (Scotland) Regulations 2007).**

**Public health advocates in other countries may wish to consider action that would promote similar legislation to reduced alcohol-related disease and harm.**

Dr Bruce Ritson (Chair), an ardent campaigner on alcohol and health, has overseen the production of a seminal report in terms of style, content and clarity. The Report merits a wide international readership, and its usefulness for advocates could have far-reaching impact. The arguments for and against using pricing and taxation policies are clearly stated and well referenced. The industry’s position is taken into account together with consideration of the political realities in introducing change. There is a strong rationale presented on why alcohol policies need to reach the majority of drinkers (Section Three), and a detailed appendix on the relationship between alcohol, price and consumption (Appendix 1).

**The Report concludes that:**

*“Having reviewed the international evidence linking price, consumption and harm; and considered the mechanisms for raising alcohol price in Scotland and the UK, this report advocates using price as a policy lever to reduce alcohol consumption and related harm. Based on estimates by the Academy of Medical Sciences, a 10% rise in alcohol price would save the lives of 479 Scottish men and 265 women every year.”*

*Calling time: The nation’s drinking as a major health issues*, Academy of Medical Sciences, March 2004) Conclusions and Recommendations (p.13)

1 “New Alcohol Health Alliance calls for tougher measures on Alcohol”. Alcohol Alert Issue 1, 2008 issn 1460-7174

**2 RECOMMENDATION 3 (p.16)  
The Scottish Government should make representation to Westminster to increase alcohol duty and link alcohol taxes to inflation.**

Increasing the rates of duty on all categories of alcoholic drinks is a simple, straightforward means available to the Westminster government to raise alcohol price. It is possible for alcohol producers and retailers to absorb the costs of a tax increase without increasing the retail price of alcohol, and this is particularly likely in the case of big supermarkets that can subsidise losses on alcohol with profits from other products. However, the evidence suggests that most producers and retailers generally pass on the costs of tax increases to consumers. In addition to raising the duty on alcohol, the Westminster government should also index-link tax increases to counter the erosion of the real value of specific alcohol duties in nominal terms due to inflation.

**3 RECOMMENDATION 4 (p.17)  
The Scottish Government should make representation to Westminster to link levels of taxation to alcohol strength.**

Increasing levels of taxation on stronger alcoholic beverages and reducing the level of taxation on lower strength beverages would give a financial incentive to consumers to buy and consume lower-strength drinks (provided the reduction or

**The full Report is available online:**

SHAAP  
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Fax: 0131 247 3664  
Email: shaap@rcpe.ac.uk  
Website: www.shaap.org.uk

increase in tax was reflected in the retail price) and to producers to produce lower-strength products.

Although the way excise duty is levied in the UK is subject to rules laid down by the EU, EU law allows taxes other than excise duty to be placed on alcohol products by individual member states. This gives the UK government scope to place further taxes, in addition to excise duty, on alcoholic beverages with higher alcohol content with the aim of reducing alcohol consumption and improving public health.

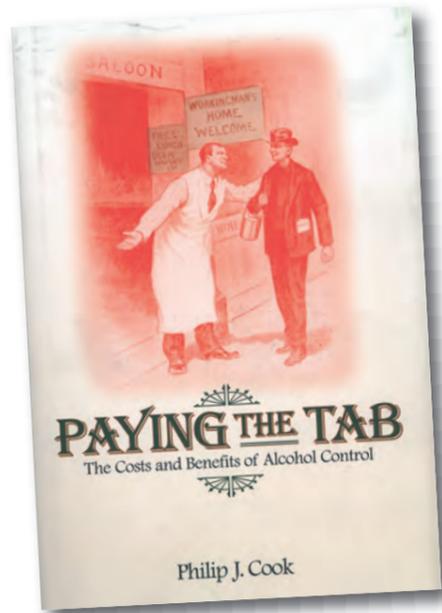
In particular, the duty on cider should be increased in relation to its alcoholic strength and taxed at the same rate as beer, a comparable alcoholic beverage. Under the current excise arrangements, cider is taxed at a much lower rate than beer of an equivalent alcoholic strength.

# Paying the Tab

## The Costs and Benefits of Alcohol Control

Philip J Cook

**Publisher:**  
Princeton University Press  
41 William Street, Princeton  
New Jersey, USA  
3 Market Place, Woodstock,  
Oxford, UK



Professor Cook has written a masterly book on alcohol control policy. The book provides a critical analysis of approaches to alcohol policy in the USA from the Temperance Movement, to the enactment and repeal of prohibition, the ascendancy of the disease model advocated by AA and the alcoholism movement and to the fresh awakening of public health advocacy. Whilst the book provides a historical overview of the way in which these different alcohol strategies have been advocated and applied in the USA, it is nonetheless a useful primer for advocates of alcohol policy in other countries.

Effective advocacy must be evidence-based and Professor Cook's book meets this essential criterion.

The Twenty First Amendment (Repeal of Prohibition) permits each State to establish its own alcohol control policy. Since this gives rise to interstate differences in policy and changes in key policy areas, it provides what social scientists have termed a 'social science laboratory' that can provide some of the strongest evidence on the effects of alcohol control policy. Cook effectively illustrates this with the changes that took place over the minimum legal drinking age during the 1970s and 80s – a period when States reduced the drinking age from 21 to 18 and then reversed the trend back to 21. This was due to the increase in youthful highway fatalities in States that had reduced the age limit compared with those that had not.

One of the main themes in the book is that alcohol is too cheap. Professor Cook deals with those that object to the use of tax by answering their objections that if price is high then drinkers would seek other substitutes, the creation of a black market

and a decline in healthy drinking (protective effect). He also deals with the notion that excise is a regressive tax.

Between 1951 and 2005 Congress legislated for an increase in beer and wine excise only once and there were only two small increases in spirits excise.

Whilst public opinion surveys indicate support for raising alcohol taxes, the alcohol industry has pushed hard for Congress to reduce alcohol taxes. The beer industry and its lobby is particularly powerful and in 2005 a majority of Congress (240 members) agreed a Bill that would have halved the duty on beer.

Cook develops the theme whether alcohol is paying its way in the light of the external costs to society.

Price matters in alleviating the harm done by the use of alcohol. Cook demonstrates that increased consumption increases injury rates from accidents and violence and that both consumption and related damages fall in response to price increases – such evidence has accumulated over the past 25 years.

Cook estimates that a 10 cent per ounce increase on ethanol (a nickel per drink) would reduce per capita consumption by 12% and the following decreases in motor vehicle fatalities 7%; fatalities from falls 9%; suicide rate 6% and cirrhosis death rates by 32%. Cook makes a final plea for the need to recapture some of the ground that has been lost in the last few decades by a selective strengthening of alcohol control guided by the evidence and common sense.

The book should find a place on the library shelf of all alcohol policy advocates.



## 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

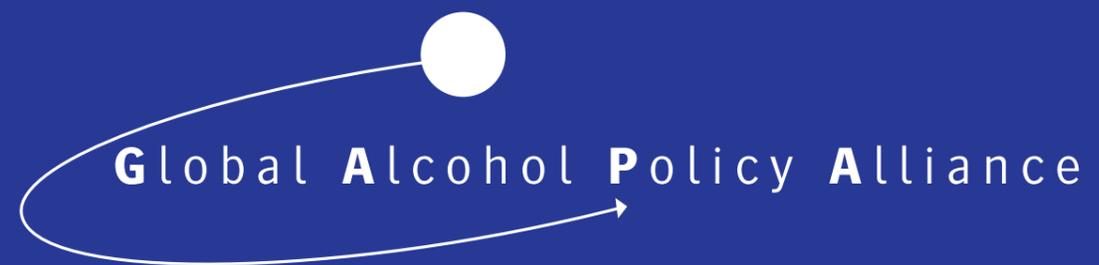
**Alcohol Problems in the Family: A Report to the European Union**

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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