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Toward a Global Alcohol Strategy

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Global Alcohol Strategy

on the right track

After more than 20 years on the periphery alcohol was put centre stage in global public health in 2005 when the 58th World Health Assembly (WHA) passed the resolution, “Public health problems caused by harmful use of alcohol” (WHA58.26). This move was not free from controversy and an attempt to pass a new resolution in 2007 failed due to the opposition of some Member States. In May 2008, the Members States were again able to reach consensus on a new alcohol resolution, this time drafted by the group of African countries. This resolution called for a WHO-sponsored Global Strategy to Reduce Harmful Use of Alcohol (WHA61.4).

Since 2008 the WHO Secretariat has been working on developing the global strategy. There exists a strong evidence base on the harm from alcohol as well as the cost effective interventions available. Among other documents this evidence base is summarized in the 2007 report from the WHO Expert Committee on Problems Related to Alcohol Consumption. In addition WHO has engaged in a process of broad consultation including an open web-based solicitation of comments, and round table meetings with economic operators, NGOs and health professionals, and intergovernmental organizations and UN agencies.

The Secretariat also organized a series of collaborative meetings with Member States in each region, and prepared a Working

Document which suggested the direction sought in the ultimate Global Strategy. At an informal consultation with Member States on 8 October 2009 in Geneva the Secretariat received feedback on several aspects of the Working Document. A revised Draft Global Strategy was then published in December as part of the documentation for the 126th Executive Board meeting of WHO to be held in January 2010.

Several changes have appeared in the Draft Strategy compared to the previous Working Document. In the Executive Board (EB) meeting the Member States will have the opportunity to address the various parts of the strategy. The EB will then forward the strategy and an accompanying resolution for consideration by the World Health Assembly in May 2010.

The Global Alcohol Policy Alliance reviewed the Working Document and found it to be a good start which should be supported. The present Draft Strategy has been improved in some aspects, but weakened in others. A key area of concern is the revised section on marketing, which supports co-regulation and self-regulation “as appropriate” as parts of the strategy. There is no evidence for the effectiveness of either co-regulation or self-regulation of alcohol marketing. For instance, voluntary codes of good marketing practice are consistently violated in sports sponsorships, and

WHO Member States should seriously consider a ban on such sponsorships. The Working Document included bans on this and other forms of marketing as viable policy options; the revised Draft Global Strategy has removed this language. In this area as elsewhere, the evidence base for the strategy is strong and the strategy should remain consistent with that evidence base, particularly regarding the availability (including formal and informal sectors), marketing and pricing of alcohol.

Distinctions made in the draft strategy regarding the roles of different parties are essential, including language regarding conflicts of interest. The engagement of civil society is essential. Economic operators in alcohol production and trade should be seen as players only in their role as developers, producers, distributors, marketers and sellers of alcohol beverages. Appropriate consideration must be given to the commercial interests involved and their conflict with public health objectives.

Along with the Global Strategy there needs to be clear resourcing available for the ongoing development and implementation of the strategy, at global, regional and national levels. Well-resourced countries should be encouraged to indicate how they will contribute resources for the implementation of the strategy. The mobilization, involvement and engagement of civil society will be critical to implementation of the strategy and to establishing the political will to support that implementation. In this regard, GAPA stands ready to contribute.

Øystein Bakke
Secretary, GAPA

Draft global strategy to reduce harmful use of alcohol

Summary of the Report

Setting the scene

Alcohol is the fifth leading risk factor for premature deaths and disabilities in the world; in 2004, 2.5 million people worldwide died of alcohol-related causes including 320 000 young people between 15 and 29 years of age – representing 3.8% of all deaths and 4.6% of the global burden of disease. Harmful drinking is a major avoidable risk factor for neuropsychiatric disorders and other non-communicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers. It is also associated with several infectious diseases: HIV/AIDS, tuberculosis and pneumonia. A significant proportion of the disease burden arises from unintentional and intentional injuries. Fatal injuries attributable to alcohol consumption tend to occur in relatively young people. Whilst there exists a substantial scientific knowledge base for policy makers on the effectiveness and the cost effectiveness of strategies to prevent and reduce alcohol related harm, policy responses are often fragmented and do not always correspond to the magnitude of the impact on health and social development.

Challenges

The current worldwide health, cultural and market trends mean that harmful use of alcohol will continue to be a global health issue. The need is for intersectoral action - development, transport, justice, social welfare, fiscal policy, trade, agriculture, consumer policy, education and employment. Preventing and reducing harmful use of alcohol is often given a low priority among decision-makers despite compelling evidence of its serious public health effects. There is a discrepancy between the increasing availability and affordability of alcohol in many low and middle-income countries, affecting their capability to meet the resultant public health burden. Production, distribution, marketing and sales of alcohol create employment and generate considerable income for economic operators and tax revenue for governments at different levels. Public health measures can be seen as harming economic interests and reducing government revenues. Policy-

makers face the challenge of giving an appropriate priority to the promotion and protection of population health while taking into account other goals, obligations and interests. In this respect, it should be noted that international trade agreements generally recognize the right of countries to take measures to protect human health, provided they are not discriminatory or disguised restrictions on trade.

Population-wide rates of alcohol consumption are markedly lower in poorer societies than in wealthier ones. However, for a given amount of consumption, poorer populations may experience disproportionately higher levels of alcohol-attributable harm. There is a great need to develop and implement effective policies and programmes that address such social disparities and to generate and disseminate new knowledge about the complex relationship between alcohol and social and health inequity, particularly in developing countries.

Objectives

The strategy has five objectives:

- raised global awareness of the magnitude and nature of the health, social and economic problems caused by harmful use of alcohol, and increased commitment by governments to act to address the harmful use of alcohol;
- strengthened knowledge base on the magnitude and determinants of alcohol-related harm and on effective interventions to reduce and prevent such harm;
- increased technical support to, and enhanced capacity of, Member States for preventing the harmful use of alcohol and managing alcohol-use disorders and associated health conditions;
- strengthened partnerships and better coordination among stakeholders and increased mobilization of resources required for appropriate and concerted action to prevent the harmful use of alcohol;

- improved systems for monitoring and surveillance at different levels, and more effective dissemination and application of information for advocacy, policy development and evaluation purposes.

The strategy considers that national and local efforts to reduce harmful use of alcohol can produce better results when they are supported by regional and global action within agreed public health policy frameworks.

GUIDING PRINCIPLES

The principles lying behind the strategy are:

- Public policies and interventions to prevent and reduce alcohol-related harm should be guided and formulated by public health interests and based on clear public health goals and the best available evidence.
- Policies should be equitable and sensitive to national, religious and cultural contexts.
- All involved parties have the responsibility to act in ways that do not undermine the implementation of public policies and interventions to prevent and reduce harmful use of alcohol.
- Public health should be given proper deference in relation to competing interests and approaches that support that direction should be promoted.
- Protection of populations at high risk of alcohol-attributable harm and those exposed to the effects of harmful drinking by others should be an integral part of policies addressing the harmful use of alcohol.
- Individuals and families affected by the harmful use of alcohol should have access to affordable and effective prevention and care services.
- Children, teenagers and adults who choose not to drink alcohol beverages have the right to be supported in their non-drinking behaviour and protected from pressures to drink.

National policies

The harmful use of alcohol, and its related public health problems, is influenced by the general level of alcohol consumption in a population, drinking patterns and local contexts.

Special attention needs to be given to reducing harm to people other than the drinker and to populations that are at particular risk from harmful use of alcohol, such as children, adolescents, women of child-bearing age, pregnant

and breast-feeding women, indigenous peoples and other minority groups or groups with low socioeconomic status.

Member States have a primary responsibility for formulating, implementing, monitoring and evaluating public policies to reduce the harmful use of alcohol. Sustained political commitment, effective coordination, sustainable funding and appropriate engagement of sub-national governments and civil society are essential for success. Governments need to establish effective and permanent coordination machinery, such as a national alcohol council, comprising senior representatives of many ministries and other partners, in order to ensure a coherent approach to alcohol policies and a proper balance between policy goals in relation to harmful use of alcohol and other public policy goals. Health ministries have a crucial role in bringing together the other ministries and stakeholders needed for effective policy design and implementation.

Policy Options

Ten target areas that should be seen as supportive and complementary are available for national action:

leadership awareness and commitment

Sustainable action requires strong leadership and a solid base of awareness, political will and commitment. The commitments should ideally be expressed through adequately-funded comprehensive and inter-sectoral national policies that clarify the contributions and responsibilities of the different partners involved. The policies must be based on available evidence and tailored to local circumstances, with clear objectives, strategies and targets. The engagement of civil society is essential. Policy options and interventions include: developing comprehensive and adequately-funded national and sub-national strategies; establishing a body to be responsible for following up national policies, strategies and plans; coordinating alcohol strategies with other relevant government sectors; ensuring broad access to information, effective education, effective prevention measures and public awareness programmes among all levels of society.

health services' response - central to tackling harm at the individual level among those with alcohol use disorders and providing prevention and treatment interventions to individuals and their families at risk of or affected by alcohol use disorders. An important role for the sector is to inform societies and their members about the public health and social consequences of the harmful use of alcohol, and to advocate for effective societal responses.

community action

Community level action can: identify gaps and priority areas for interventions; facilitate increased recognition of alcohol-related harm; promote appropriate responses to the local determinants of harmful use of alcohol and related problems; strengthen the capacity of local authorities to encourage and coordinate community action by the development of municipal alcohol policies; mobilize communities to prevent the selling of alcohol to, and consumption of alcohol by under-age drinkers, and to develop and support alcohol-free environments, especially for youth and other at-risk groups.

drink-driving policies and countermeasures

A significant public health problem that affects both the drinker and other innocent parties. Strategies that reduce harm include deterrent measures and measures that create a safer driving environment. Policy options: promoting sobriety check points and random breath-testing; administrative suspension of driving licences; graduated licensing for novice drivers with zero-tolerance for drink-driving; using an ignition interlock, as appropriate, to reduce drink-driving incidents; mandatory driver-education, counselling and treatment programmes.

availability of alcohol

Regulating the commercial or public availability of alcohol are important ways to reduce the general level of harmful use and provides an essential measure to prevent easy access to alcohol by vulnerable and high-risk groups.

marketing of alcoholic beverages

Reducing the impact of marketing is an important consideration in reducing harmful use. Alcohol is marketed through increasingly sophisticated advertising and promotion techniques, including linking alcohol brands to sports and cultural activities, sponsorships and product placements and new marketing techniques such as e-mails, SMS and podcasting, social media and other communication techniques. The transmission of alcohol marketing messages across national borders and jurisdictions on channels such as satellite television and the Internet, and sponsorship of sports and cultural events are emerging as a serious concern in some countries.

It is very difficult to target young adult consumers without exposing cohorts of adolescents under the legal age to the same marketing. The exposure of children and young people to appealing marketing is of particular concern, as is the targeting of new markets in low- and middle-income countries with a current low prevalence of alcohol consumption or high abstinence rates.

Both the content of alcohol marketing and the amount of exposure of young people to that marketing are crucial issues. A precautionary approach to protecting young people against these marketing techniques should be considered. Policy options include: setting up regulatory or co-regulatory frameworks, preferably with a legislative basis, and supported when appropriate by self-regulatory measures. Regulating: the content and the volume of marketing; direct or indirect marketing in certain or all media; sponsorship activities that promote alcoholic beverages; restricting or banning promotions in connection with activities targeting young people.

pricing policies

Consumers, including heavy drinkers and young people, are sensitive to changes in the price of drinks. Pricing policies can be used to reduce underage drinking, to halt progression towards drinking large volumes of alcohol and/or episodes of heavy drinking, and to influence consumers' preferences. Increasing the price of alcoholic beverages is one of the most effective interventions to reduce harmful use of alcohol. The existence of a substantial illicit market for alcohol complicates policy considerations on taxation in many countries. In such circumstances, tax changes must be accompanied by efforts to bring the illicit and informal markets under effective government control. Increased taxation can also meet resistance from consumer groups and economic operators, and taxation policy will benefit from the support of information and awareness-building measures to counter such resistance.

reducing the negative consequences of drinking and alcohol intoxication

Includes policy options and interventions that focus directly on reducing the harm from alcohol intoxication and drinking without necessarily affecting the underlying alcohol consumption. This approach is often referred to as a harm reduction approach. Current evidence and good practices favour the complementary use of harm-reduction interventions together with broader strategies to prevent or reduce harmful use of alcohol. In implementing these harm-reduction approaches to managing the drinking environment or informing consumers, the perception of endorsing or promoting drinking should be avoided.

reducing the public health impact of illegal and informal alcohol

Consumption of illicitly or informally produced alcohol could have additional negative health

consequences due to a higher ethanol content and potential contamination with toxic substances. It may also hamper governments' abilities to tax and control legally produced alcohol. Actions to reduce these additional negative effects should be taken.

monitoring and surveillance

Local, national and international monitoring and surveillance are needed in order to monitor the magnitude and trends of alcohol-related harms, to strengthen advocacy, to formulate policies and to assess impact of interventions.

GLOBAL ACTION

Concerted global efforts must be in place to support Member States in the challenges they face at the national level. International public health advocacy and partnership are needed for strengthened commitment and abilities of governments and all relevant parties at all levels for reducing harmful use of alcohol worldwide.

Role of WHO and UN Partners

WHO will: provide leadership; strengthen advocacy; formulate, in collaboration with Member States, evidence-based policy options; promote networking and exchange of experience among countries; strengthen partnerships and resource mobilization; coordinate monitoring of alcohol-related harm and the progress countries are making to address it.

Action by WHO and other international partners to support the implementation of the global strategy will be taken according to their mandates. Major partners within the United Nations system like ILO, UNICEF, WTO, UNDP, UNFPA, UNAIDS, United Nations Office on Drugs and Crime, and the World Bank group will be urged to increase collaboration and cooperation to prevent and reduce harmful use of alcohol, especially in low- and middle-income countries.

International public health advocacy and partnership are needed for strengthened commitment and abilities of governments and all relevant parties at all levels for reducing harmful use of alcohol worldwide.

WHO will engage with other international intergovernmental organizations and, as appropriate, international bodies representing

key stakeholders, to ensure that relevant actors can contribute to reducing the harmful use of alcohol.

WHO is committed to resource mobilization and pooling of available resources to support global and national action to reduce harmful use of alcohol in identified priority areas.

WHO will ensure that the Secretariat has processes in place to work with non-governmental organizations and other civil society groups, taking into consideration any conflicts of interest that some nongovernmental organizations may have; continuing its dialogue with the private sector on how they can best contribute to the reduction of alcohol-related harm. Appropriate consideration will be given to the commercial interests involved and their possible conflict with public health objectives.

The Secretariat will support Member States by:

- providing an international clearing house for information on effective and cost-effective interventions to reduce harmful use of alcohol, including promoting and facilitating exchange of information about effective treatment services;
- strengthening the Global Information System on Alcohol and Health and the comparative risk assessment of the alcohol-attributable disease burden;
- developing or refining appropriate data-collection mechanisms, based on comparable data and agreed indicators and definitions, in order to facilitate data collection, collation, analysis and dissemination at the global, regional and national levels;
- facilitating regional and global networks to support and complement national efforts, with a focus on knowledge production and information exchange;
- continuing its collaboration with international networks of scientists and health experts to promote research on various aspects of harmful use of alcohol;
- facilitating comparative effectiveness studies of different policy measures implemented in different cultural and developmental contexts;
- facilitating operational research to expand effective interventions and research on the relationship between alcohol and social and health inequities;
- promoting exchange of experience and good practice in financing policies and interventions to reduce harmful use of alcohol;
- exploring new or innovative ways and means to secure adequate funding for implementation of the global strategy;

- collaborating with international partners, intergovernmental partners and donors to mobilize necessary resources to support low- and middle-income countries in their efforts to reduce harmful use of alcohol;
- assisting in resource mobilization for community action in low- and middle-income countries.

NGOs and other bodies

International non-governmental organizations, professional associations, research institutions and economic operators in the area of alcohol, all have important roles in enhancing the global action:

Civil society has an important role in warning about the impact of harmful use of alcohol on individuals, families and communities and in bringing additional commitment and resources for reducing alcohol-related harm. Non-governmental organizations are especially encouraged to form wide networks and action groups to support the implementation of the global strategy.

Research institutions and professional associations play a pivotal role in generating additional evidence for action and disseminating this to health professionals and the wider community.

WHO collaborating centres have an important role in supporting the implementation and evaluation of the global strategy.

Development agencies could consider reducing harmful use of alcohol as a priority area in low- and middle-income countries with a high burden of disease attributable to alcohol. Official Development Assistance provides opportunities to build sustainable institutional capacity in this area in low- and middle-income countries, as do mechanisms for collaboration between developing countries.

Economic operators in alcohol production and trade are important players in their role as developers, producers, distributors, marketers and sellers of alcoholic beverages. They are especially encouraged to consider effective ways to prevent and reduce harmful use of alcohol within their core roles mentioned above, including self-regulatory actions and initiatives. They could also contribute by making available data on sales and consumption of alcohol beverages.

The media play an increasingly important role, not only as conveyers of news and information but also as channels for commercial communications, and will be encouraged to support the intentions and activities of the global strategy.

IMPLEMENTING THE STRATEGY

Successful implementation of the strategy will require concerted action by Member States, effective global governance and appropriate engagement of all relevant stakeholders. The Secretariat will report regularly on the global burden of alcohol-related harm, make evidence-based recommendations, and advocate action at all levels to prevent and reduce harmful use of alcohol. It will collaborate with other intergovernmental organizations and, as appropriate, other international bodies representing key stakeholders to ensure that action to reduce harmful use of alcohol receives appropriate priority and resources.

The implementation of a global strategy to reduce harmful use of alcohol provides a supportive framework for the WHO regional offices to formulate, revisit and implement region-specific policies and, together with the country offices, provide technical support to Member States. Emphasis will also be put on coordination within the Secretariat so that all actions relevant to harmful use of alcohol are in line with this strategy.

For monitoring progress, the strategy requires appropriate mechanisms at different levels for assessment, reporting and re-programming. A framework with an impact-focused perspective is needed for assessing achievement of the strategy's objectives.

WHO's Global Survey on Alcohol and Health and the Global Information System on Alcohol and Health will be important parts of the reporting and monitoring mechanisms. The data-collecting tools of the latter will be adjusted to include the relevant reporting on the process and outcomes of implementation of the strategy at the national level.

Regular meetings of global and regional networks of national counterparts offer a mechanism for technical discussion of the implementation of the global strategy at different levels. In addition to taking stock of the process, these meetings could include detailed discussions of priority areas and topics relevant to implementation. Reporting on the implementation of the strategy will take place through regular reports to WHO regional committees and the Health Assembly. Information about implementation and progress should also be presented at regional or international forums and appropriate intergovernmental meetings.

Swedish Presidency Major Alcohol Conference in Stockholm

On Monday 21 September, the European Union Swedish Presidency began a two-day expert conference on alcohol and health. Around 450 participants from EU institutions and Member States, as well as from a range of stakeholder organisations, gathered at Norra Latin Conference Centre in Stockholm.

The backdrop to the conference was the unacceptably high level of alcohol-related harm in the EU, one of the major issues Sweden has chosen to highlight during its Presidency. One of the messages of the Swedish Presidency is that effective methods exist for preventing and reducing the harm caused by alcohol, and, used properly, these methods could save thousands of lives and give increased protection to children and young people.

The event was designed to support the Alcohol Strategy adopted by the Commission and the Council of the European

Union in 2006. Opening the conference, Maria Larsson, Swedish Minister for Elderly Care and Public Health said:

“We need to increase our efforts and raise the degree of awareness to a higher level. Harmful drinking is not just a problem for the individual. It is also a problem for the family, health and medical services and the whole of society. The number one goal of the EU Alcohol Strategy is to protect children, young people and unborn children from alcohol-related harm.”

The protection of children was the theme of the first day of the conference. “Exposure to alcohol during fetal life may disturb the fine tuning that the wiring of the brain goes through at different levels,” said Professor Hugo Lagercrantz, who introduced the section of the conference concerned with ways to protect the unborn child.

Robert Madelin, Director-General of the European Commission’s Directorate General for Health and Consumer Affairs (SANCO), concluded this part of the conference. “Europe is still the region with the highest alcohol consumption in the world,” he said. “A well-balanced mix of effective methods is needed to



Maria Larsson, Swedish Minister for Elderly Care and Public Health

reduce alcohol harm in the EU. One of the ingredients in this mix is restrictions. Another is increased involvement on the part of economic actors.”

The afternoon conference theme was ways of protecting children and young people from different forms of alcohol commercial communication. “Evidence shows that alcohol marketing increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already drinking,” said public health consultant Dr Peter Anderson. The afternoon programme ended with a round table discussion on the topic ‘Are we doing enough to protect children and young people?’ led by Robert Madelin, in which Maria Larsson also participated.



A welcome from young people at the Opening Ceremony

EU ALCOHOL STRATEGY MAKES A PROMISING START

But Eurocare worried about alcohol industry influence

Director General Robert Madelin defends involvement of the industry: attacks 'apartheid' approach to alcohol policy

The adoption of the EU Alcohol Strategy in October 2006 has prompted considerable activity in the European Commission and in the Member States and this makes for a very promising start in tackling the alcohol issue, although much more remains to be done.

This is the main conclusion of the first progress report on the Strategy prepared by the Commission.

Meanwhile, Eurocare, the main alcohol policy advocacy group in the EU, published its own 'shadow' progress report on the Strategy based on feedback from Eurocare member organisations across Europe. This found that, while Eurocare members expressed strong support for the aims and objectives of the Strategy, most were skeptical that it would, of itself, significantly reduce the number of casualties from alcohol related harm, and they were also worried that the alcohol industry was being given the opportunity to obstruct progress and to divert activity into areas that are relatively ineffective in reducing harm.

However, speaking exclusively to The Globe, Director General Robert Madelin, the driving force behind the EU Alcohol Strategy, defended the Commission's strategy of involving the alcohol industry. Mr Madelin said that he believed strongly in the value of co-operation and that all stakeholders had a duty to engage with the alcohol policy process. He said:

"To say that different players have different roles is one thing. But I don't think you can have a sort of apartheid approach towards policy making, and I think, in particular, that in an area which is focused on the behaviour of citizens in society, in today's society in Europe, you'll never achieve behavioural change by an apartheid approach."

The full interview with Mr Madelin is on pages 14-17.

European Commission Progress Report

The EC progress report states that, since the adoption of the Strategy, there has been considerable activity on the part of the Commission, the Member States and the wider stakeholders to set up the infrastructure for implementation.

The Strategy defines five priorities:

- The protection of young people, children and the

unborn child from alcohol harm

- Reducing injuries and deaths from alcohol related road traffic accidents
- Preventing alcohol harm in adult populations
- Informing, educating and raising awareness of the impact of harmful alcohol consumption
- Developing and maintaining a common evidence base at EU level.

The structure put in place by the Commission to implement the strategy and to achieve the priorities is based on four main pillars:

- Strengthened co-ordination and policy development between Member States and the European Union level, through the Committee on National Alcohol Policy and Action
- Stimulation of concrete stakeholder-driven action on the ground, through the European Alcohol and Health Forum
- Development of reliable, comparable and regularly updated data on alcohol consumption, drinking patterns and alcohol-related harm, as well as on common indicators and definitions, through the Committee on Data Collection, Indicators and Definitions

- Mainstreaming the reduction of alcohol-related harm into other Community policies.

A number of other Community policy areas, such as Transport, have taken concrete actions that contribute to the priority areas of the Alcohol Strategy. A range of alcohol-focused projects have been carried out under Community Health Programmes 2003-2008. These have included Bridging the Gap, designed to promote networking and collaboration in alcohol policy, and the development of advocacy training and tool-kits for advocates, and its successor project Building Capacity. The progress reports summarises activity at Member State level as a steady convergence of actions towards those identified as good practice. Most Member States now have a written alcohol policy in place. There is a continuous trend towards an age limit of 18 years for selling and serving alcohol, and towards lowered Blood Alcohol Concentration limits for drivers of motorised vehicles.

Wider stakeholders have been engaged in the Alcohol Strategy through the European Alcohol and Health Forum. Members of the Forum include public health NGOs, alcohol manufacturers and producers and health professionals, and membership has grown to over 60. Members have launched over 100 commitments to act to reduce alcohol related harm, and a balanced group of Forum Members has closely explored a range of specific topics; such as marketing communication, national structures for self regulation, and youth. The Forum's Science Group has

Status of National Strategies on alcohol in EU Member States		
National strategy adopted or revised 2006 or later	10	Cyprus, Finland, Italy, Latvia, Netherlands, Poland, Portugal, Slovak Republic, UK
National strategy revised before 2006	8	Czech Republic, Germany, Ireland, Lithuania, Portugal, Romania, Spain, Sweden
No national strategy on alcohol or strategy at sub-national level only	11	Austria, Belgium, Bulgaria, Estonia, France, Greece, Hungary, Luxembourg, Malta, Slovenia

adopted a scientific opinion on the relationship between marketing communication and the volume and pattern of young peoples' alcohol consumption, which opinion will be valuable for developing the next steps in relation to this topic.

The next EC progress report on the Alcohol Strategy is due in 2012.

The EC Progress Report can be accessed at: http://ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_en.htm

Eurocare Shadow Report: Alcohol Strategy essential but could be improved

The Eurocare Shadow Report offers strong support to the Commission in carrying out the Strategy while also adopting a critical stance in relation to some aspects. A key Eurocare conclusion is that while the present Strategy is a crucial first step, the goal now should be to work towards setting specific targets for reductions in the harmful consumption of alcohol and in levels of alcohol related disease and social damage.

The Eurocare Report comments that while the Strategy was eagerly awaited by the public health community, it was, in

the end, a considerably watered down version of the draft that had initially been put forward by DG SANCO. From the beginning, the Commission announced that it would not put forward any legislative measures, the justification for this being the "existence of different cultural habits related to alcohol consumption".

This disappointed many public health experts, who regarded the Strategy as not wholly serious, lacking targets and a budget, and having been weakened as it evolved.

The report makes it clear, however, that overall, Eurocare welcomes the EU Alcohol Strategy, a public health victory in itself, in that it was adopted despite the strong opposition of sections of the alcohol industry. There is, therefore, strong Eurocare support for the priorities as defined in the Strategy and strong support for its continuation.

In regard to priorities, there is a great degree of unanimity regarding the protection of young people; this is of vital importance for all Eurocare members. Reducing road deaths is also regarded by virtually all as a very high priority. There is a suggestion that the middle-aged

and elderly populations should have a higher priority, as that is where harm is concentrated and it will have an impact on young people (as middle aged often are parents as well).

However, Eurocare members are concerned over the developments in other directorates in the European Commission, or lack of them. Reducing alcohol related harm, the Eurocare report says, does not seem to have a high priority when issues like cross border trade, taxes and agricultural support are discussed and legislated.

There is a need for a more targeted approach. Member States need to make the Strategy more focused and develop specific agreed objectives such as a defined reduction in total alcohol consumption and liver cirrhosis deaths by a certain year; maximum BAC 0,2 in all EU Member States; a European standardized unit of alcohol etc.

There is also a concern about what will happen in the coming five years with a new European Parliament, New Commission and expected changes internally within DG SANCO – will the support for the Strategy be continued?

Eurocare members tend to think that the Strategy in itself may not bring about major reductions in casualties, unless actions are stepped up. The Strategy gives insufficient emphasis to the priorities identified. This leads to an implied belief that priorities are not being pursued vigorously enough. There is a need to formulate more specific targets, whilst also working harder at promoting a coherent approach through health in other policies.

The Eurocare report can be accessed at: http://www.eurocare.org/library/latest_news/eu_alcohol_strategy_progress_report

GAPA Board meets in Sweden

The EU conference on Alcohol and Health and the WHO meeting that followed provided the opportunity for the members of the GAPA Board to meet.

Members present were Derek Rutherford, Chairperson UK; Dr Sally Casswell, Chair of Professional Committee New Zealand; Øystein Bakke, Secretary, Norway; Dr Michel Craplet, France; Dr David Jernigan, USA; Sven Olov Carlsson, Sweden; George Hacker, USA; Dr S. Arulraj, India; Professor Udomsil, Thailand; Dr Ronaldo Laranjeira, Brazil and Dr Isidore Obot, Nigéria.

The following observers attended during parts of the meeting Thaksaphon Tamarangsi, Thailand; Nathalie Rodriguez McCullough and Jan Peloza, European Alcohol Policy Youth Network and Florian Stigler,

International Federation of Medical Students. Board members made brief situation reports on their regions. Of note was a new law in Brazil on drink driving lowering BAC levels from 0.6 to 0.0 (in practise 0.2). This has led to a decrease in drink driving accidents and the prevalence of drinking and driving.

A shortening of licensing hours in the city of Diadema led to a significant decrease in homicides in the city. An East African Alcohol Policy Alliance had been launched, with Rogers Kasirye of Uganda as the head. The CRISA conference in Nigeria last year led to an Alcohol Prevention Youth Network being established. In Thailand a campaign collected 4 million signatures that helped in passing the new alcohol control law.



Anna Carlstedt, President of IOGT-NTO, Sweden, hosts a luncheon for Members of GAPA Board

WHO Strategy: General approval was given to the draft strategy. The mobilization, involvement and engagement of civil society will be critical to its implementation. Well-resourced countries should be encouraged to indicate how they would contribute resources for the implementation of the strategy.

European Economic and Social Committee calls for statutory controls on alcohol marketing

Self-regulation ‘not enough’

As requested by the Swedish Presidency, the European Economic and Social Committee (EESC) has presented its views on alcohol-related harm in European society. The EESC calls for stricter controls on alcohol marketing and pricing policies in order to reduce problems associated with alcohol consumption.

These measures are aimed at reducing the proportion of people estimated to drink harmful levels of alcohol in the EU, which currently amounts to 15% of the adult population, as well as protecting children from its consequences.

At its plenary session of 30 September 2009, the EESC adopted the opinion on how to make the EU strategy on alcohol-related harm sustainable,



Ms Jillian van Turnhout

long-term and multisectoral, by rapporteur Ms Jillian van Turnhout (Group III, Various Interests, Ireland).

The EESC's opinion supports the implementation of an EU horizontal strategy in order to fight against the health-related, social and economic consequences of alcohol abuse and to promote responsible alcohol consumption.

The EESC opinion focuses on protecting children, who are particularly vulnerable to the problems caused by alcohol abuse. The rapporteur maintained that “in the EU, 5 to 9 million children in families are adversely affected by alcohol.” Moreover, the marketing of alcoholic beverages increases the likelihood that children and adolescents will start to use alcohol, and will drink more if they are already using alcohol.

The full opinion states:

Alcohol marketing is one of the factors that increases the likelihood that children and adolescents will start to use alcohol, and will drink more if they are already using alcohol. Given this, the EESC calls for a reduction in the exposure of children to alcohol marketing.

Appropriately designed alcohol pricing policies can be effective

levers in reducing alcohol related harm, particularly among low income and young people. The EESC believes that regulation governing the availability, distribution and promotion of alcohol is needed; self-regulation in this area is not enough.

Apart from the medical consequences of alcohol abuse, the EESC emphasises the significance of other social and economic effects such as the increase in social costs due to health care and the loss of productivity. Ms van Turnhout also pointed out that “harmful alcohol consumption is a contributory factor for crime, violence and family deprivation, risky sexual behaviour and sexually transmitted diseases”.

To raise awareness about the risk of Foetal Alcohol Spectrum Disorder (FASD), which includes all the birth defects caused by maternal consumption of alcohol during pregnancy, the EESC supports awareness-raising campaigns at national and EU level.

The EESC also stated that more information is needed about the effects of harmful alcohol consumption on healthy and dignified ageing at an EU level.

Robert Madelin: European Commission does not support ‘an apartheid’ approach to alcohol policy making

In the run-up to the Swedish Presidency Conference, the Globe’s Andrew McNeill interviewed Robert Madelin, Director General for DG SANCO, the EC Directorate responsible for the implementation of the Alcohol Strategy.

AM The Alcohol Strategy followed on from the Food and Nutrition platform, which provided the model. What useful lessons did the Food and Nutrition Platform provide?

RM *If we consider the Alcohol Strategy first, this is still bedding in. We’re only in 2010 getting to the stage of a formal full evaluation of the Nutrition Strategy, which is older than the Alcohol Strategy. So while we’ve been worrying about alcohol forever, the Alcohol Strategy is still relatively young in terms of the EU policy cycle.*

What did we learn? I think we learned the best practice model from the Nutrition Platform in regard to requirements for monitoring, accountability and reporting, and we’ve been able to apply them directly to the alcohol process. Of course, we face the same problem on alcohol that we do on nutrition, which is that it’s a model for accountability about output, not outcomes. So we’re not yet able to measure the impact of individual measures. But that’s a



Robert Madelin

familiar problem in work on health determinants whoever is doing it, and whether it’s done under the Health Forum, or by public executives.

Another lesson we’ve learned in relation to both nutrition and alcohol is that the science is less mixed in the messages it sends to policy makers than lobbyists would have us believe. Connected with this, I think that establishing a science group in the alcohol process with balanced representation of different sorts of scientists does, therefore, seem to come out as a helpful tool even if, at this stage, the output is limited, and obviously the capacity to do work is limited because these are not people working full time on issues coming out of the Alcohol and Health Forum.

AM It seems to me that both the Food and Nutrition Platform and the Alcohol Strategy are alike in being based on the optimistic assumption that it is possible to get diverse stakeholders together, a consensus will emerge and everyone will then work towards shared goals. Does not the history of the alcohol strategy, -for example, the reaction of the alcohol industry to the IAS report ‘Alcohol and Public Health in Europe’ suggest that the industry people did not want there to be a public health strategy on alcohol?

RM *Well, it’s certainly true that if they could have delayed it further, some parts of the industry would have done that. So I think we were lucky that the responsible EU Commissioner, David Byrne, was prepared to bite the bullet and take the risk, because to have said that we were still reflecting on it would have been a more comfortable option for him.*

On the question of optimism, I wouldn’t have been a public policy maker for 30 years if I wasn’t an optimist about the ability of society to come together to fix serious problems.

I don’t think you can create trust overnight and I don’t think you can pretend that very different

opinions about what society really needs can be or should be set aside at the door. I do, however, observe that even where serious disagreement exists, talking to the other side in a structured way under public refereeship, so that it is a safe process that cannot be misrepresented by the other side, helps everybody around the table to set aside the worst of their misunderstandings. But it is a slow process.

I don't believe, however, that there is a working alternative to this process. The point is that having an Alcohol Strategy is better than not having one. The world we were in before we had an alcohol policy was one that was comfortable for economic operators because there was no EU level pressure on them to do anything. It was all left to Member States, and not all Member States were equipped to create pressure at their level.

AM At this point in the proceedings, is the process where you wanted it to be at this stage? And are you basically content with how it has developed?

RM Well, I suppose the issue on which I would put a question mark is about creating an EU 27-wide, better policed network of national self- and co-regulation on alcohol advertising. That's moving more slowly than I would perhaps hope. I want it to happen not because I see it as a panacea, because it doesn't dispose of other unanswered questions about the right level of regulation, but because I think that it's what we could do now. So that's a bit slower than I would hope.

I also think the Clearing House tool should be useful in terms of taking these anecdotes of best practice and putting them all in one place where people can see them. This is because for some of the newer Member States and for emerging actors in civil society, and even for the research community, there's still lots to learn.

But for the rest, I didn't have specific critical path deadlines for individual components because I think that, while the Commission chairs this process, we cannot determine its rate of development. That depends a lot on the individuals in the room.

AM Allowing for that, do you believe that the process is satisfactorily bringing together all the policy tools available to the EU?

RM No. Maybe two things to say there. Firstly, it's not yet satisfactorily bringing together all the actors. In regard to the economic operators, the extent of engagement down the value chain varies, so we need to work more on that. And also in terms of civil society actors, people like teachers for example, or community leaders, there are potentially other actors who can be influential at national and regional level but who are quite hard to reach sometimes from European levels. So for the people around the table I still have some recruitment ambitions.

In terms of the tools, the Forum is a tool but it's not the toolbox; therefore, there are other tools which are not in the Forum and never could be because they're public policy and this is a tool among others. In regard to the

broader debate with Member States, I think there as well it's a bit too early to judge. Member States are all beginning to move towards a more comprehensive implementation of the ideas in the Alcohol Strategy but I think many of them would say we're not quite there yet. That's something where we probably do need another year or so to judge.

AM So you are pretty confident that the EU Alcohol Strategy has had a beneficial effect at Member State level?

RM Well, the officials who come to the alcohol policy meetings seem encouraged by the fact that they have an EU level benchmark against which to push. But that's very much at working level. What we lack, I think, is a big enough focus on public health promotion as a component of health responsibilities in most if not all Member States. So the existence of the Forum and the existence of the group of officials is not, in itself, delivering that and I don't think it can. I don't think the EU can tell Member States to rebalance towards more public health promotion, but the trend is there.

AM What about within the institutions themselves, the other directorates for instance? Do you feel that they are on board satisfactorily?

RM These organisations, Nutrition Platform and the Alcohol Forum, are both set up on the basis of a very formal political decision by the Commission, which means that it's much easier to get other DGs to co-operate with them and with their policy area than it is if I just have an ad

hoc conference on youth or sport or something like that. In this particular field, perhaps there is less than other DGs can do on alcohol than there is around the food chain. For example, on the food chain it is very obvious you need DG Agriculture. Some of these issues have not yet been unpacked in the same way in the alcohol debate as they have on nutrition so I would say that, on alcohol, people in other DGs are a bit less sure what they can contribute and the Forum itself, to be honest, has not been so interested yet. In the Nutrition Platform there was a lot of desire to talk to other DGs and we haven't seen that so much on alcohol yet. Not as strong evidence of engagement as we had for nutrition, but maybe that's because we haven't been pushing them.

AM Can I ask you now about the attitudes of some of the people on the NGO side which, as you know, have been ambivalent about the Alcohol Strategy because they do not like the involvement of the alcohol industry. I assume you do not regard this kind of criticism as fair or reasonable.

RM Going back to your optimism and pessimism, I am an optimist but I expect the worst. My view on this is that every position is legitimate. In the first such Forum that I ever established, which goes back to my time working on trade policies in the 1980s, yes there were some NGOs that boycotted the process and others that chose to come into it. I think that, from the Commission's point of view, we should only embark on such processes if we're sure that they are potentially useful, and we can't

give a veto to any particular part of society. So our position is not to pre-cook the results but to be honest as public policy makers in saying we think we need more co-operation around the reduction of alcohol-related harm. And then the people who wish to join the process will, and others will not.

I personally believe, almost as a societal value, that engagement, not boycott, is the duty of responsible organisations in public policy making and I think that's true in public health and in every other field. To say that different players have different roles is one thing. But I don't think you can have a sort of apartheid approach towards policy making, and I think, in particular, that in an area which is focused on the behaviour of citizens in society, in today's society in Europe, you'll never achieve behavioural change by an apartheid approach. Yes, it's possible to reject co-operation and lobby instead for hard law public interventions, and clearly it is always possible that at some stage in the future there'll be a much bigger political will to legislate, and maybe that's all we need. But my own view is that, even if you have legislation you also need co-operation. The two are not mutually exclusive. In the area of food safety, where there are huge statute books, I still need civil society, consumers for example, and economic operators to get together and co-operate simply to implement the law.

So if the question is, are those around the table in the Forum right to be there in their own interest? I'm convinced the answer is yes. We are committed to making sure that there is no abuse or misrepresentation. Is it a useful

expenditure of their time? Only each organisation can answer that, but my own view is that if you look at the nutrition area you can see issues where the change comes out of the debate in the platform even if there are then underpinnings in legislation later.

AM But there are still fairly fundamental differences between, say, the Eurocare people on the one side and the beer and spirits people on the other.

RM I think that's true. But I would suggest that there are probably differences between economic operators, and probably also differences between NGO participants in the Alcohol Forum as well. I think part of the answer is you can't effect social change unless you engage with other actors in society so even if you're pessimistic and mistrustful, if the public authorities say we want a conversation and civil society says we don't care, we're not coming, you have to be sure you're right, but it is your call. At a second level, I am optimistic that exposing, in a structured way, the individuals working within the alcohol value chain to the knowledge and experience of voices of civil society changes them. They are getting input they don't get when they're allowed to sit just in their own little groups. So I think that there is a public good investment just sitting opposite people even if you disagree with them.

AM There is a fairly heavy emphasis on youth in the Strategy. Are you content that the appropriate means have been found for involving youth in the process, which I assume is a necessity, at least at the political level?

RM I think that the focus on youth is not because all the alcohol abuse takes place among young people. It's an optimistic endeavour to fix the future, because if the behavioural challenges which are prevalent in society can be reduced in their prevalence among the under 30s, over time the norm will change. The second point, I think, is that, in terms of health policy, Commissioner Vassiliou has made a big issue about focussing on youth across the board, not just on alcohol. So the youth focus is not specific to alcohol. Are we finding the right ways to involve youth? We're trying hard, but it's a hard to reach group. Organised youth is one thing, and there are several organisations around the alcohol issue who are there, but unorganised youth is another and I think we shouldn't just be politically correct and say you can only do youth health policy when young people are in the room. You need the voice of youth but you also need expertise about youth which doesn't only come from young people themselves.

AM The last question. Take this as flattery but with a sting in the tail. The Eurocare consultation exercise about the Strategy found that people were very happy to give you full marks for pushing the alcohol strategy along, for being the driver behind it; the sting in the tail is the question whether

it depends too much on you? In other words if you were run over by the proverbial Brussels bus, what would happen to the Alcohol Strategy?

RM Well, I am, as the Chairman of the Alcohol Forum, the visible face, but as the Eurocare members should know better than me, the alcohol policy work began long before I arrived in this job in 2004 and every day it depends on the contribution of many people who are not me, so I think that where we are today doesn't depend on one person and therefore, if that one person moves on much will depend on the successor. In terms of the personal role, I chair the Forum so whoever takes over from me when I go to another job will have to do a good job as well, and there are lots of experienced and committed people in the Commission. The Commission's rule is Directors General move between their 5th and 7th year in the job, and I've done 5 years and I'll have done 7 years at the beginning of 2011, so probably the new Commission which is expected now to come into office, lets say, very early in the New Year will make decisions about moving Directors General around sometime in 2010. So it's not an abstract question but I wouldn't personalise it as much as your commentator did even though it's deeply flattering. I think in the end if there weren't a political will to work together the Chair of a process couldn't make it work and if there is a political will to work together then the Chair of a process can clearly mess it up but the Commission has a range of good officials capable of not messing it up.

AM So you are confident that the Alcohol Strategy has been sufficiently institutionalised that it will carry on?

RM Yes. It is always possible for the next Commissioner to adjust policy, but in terms of the agenda for the next Commissioner around health determinants work the youth thread needs a push, health inequalities is the next one requiring proposals, the Nutrition Strategy needs evaluation and those would, I think, be the priorities for change and innovation in 2010. Alcohol comes after that when it's had a little bit more time but I believe that we have, in the life of this Commission, achieved the recognition that there needs to be an alcohol strategy at EU level and that the next Commission and my successor will be devoted to trying to make it more effective.

Harmful alcohol consumption hinders social progress

On Wednesday 23 September the Swedish Presidency, in cooperation with the Swedish International Development Cooperation Agency and the Norwegian Ministry of Health and Care Services, and co-sponsored by the World Health Organization, conducted a Global Expert Meeting on Alcohol, Health and Social Development. “Sweden wants to contribute increased knowledge about the role of harmful alcohol consumption in low- and middle-income countries,” said Minister for Elderly Care and Public Health Maria Larsson. “We want to contribute more knowledge about the connection between harmful use, poverty, social exclusion, the spread of communicable diseases and socio-economic development.”

The Global Expert Conference made up the third day of the events focusing on alcohol and health that the Swedish Presidency had gathered together over the three-day period from 21 to 23 September. Apart from alcohol and health issues, the Global Meeting also covered the issue of social development.

“Discussions on a global alcohol strategy have drawn attention to the fact that not all countries have a well-developed public health infrastructure and a strong welfare sector, as we do in the Nordic countries, for instance,”

said Ms Larsson. “Obviously there is a strong need to give more attention to the needs and special conditions of non-western countries, so as to support these countries in their efforts to reduce alcohol-related harm.

Developing countries seek advice and assistance

Dr Ala Alwan, Assistant Director-General of the World Health Organization, also took part in the opening ceremony of the event.

“Non-communicable diseases and their risk factors – including harmful alcohol consumption – are a global challenge,” said Dr Alwan. “Low- and middle-income countries want technical advice and assistance in their fight against such risk factors. In 2010 the World Health Organization will present its global status report on trends and risk factors. We have noted that there has been considerable development in this area recently.”

Connection between harmful alcohol consumption and sexually transmitted diseases

Dr Zsuzsanna Jakab, Director of the European Centre for Disease Prevention and Control (ECDC), spoke about the relationship between harmful use of alcohol and infectious diseases.

“The relationship has previously been underestimated,” said Dr Jakab. “But there is a strong link between alcohol consumption and the spread of sexually transmitted diseases such as HIV and chlamydia.”

Professor Jürgen Rehm, from the Centre for Addiction and Mental Health in Toronto, Canada and Technische Universität Dresden, Germany, also highlighted the relationship between harmful alcohol consumption and sexually transmitted diseases.



Professor Jürgen Rehm

“The probability of successful treatment for HIV is lessened if the patient consumes alcohol in a harmful way,” said Professor Rehm.

Professor Rehm is also principal author of the report presented at the Global Expert Meeting on Alcohol, Health and Social Development.

ALCOHOL BURDEN OF DISEASE EVEN GREATER THAN PREVIOUSLY BELIEVED

Infectious disease linked to alcohol

Developing countries worst affected

Alcohol's contribution to the global burden of disease is much greater than previously suggested if infectious diseases are also taken into account.

This is one of the conclusions of an investigation into the problem commissioned by the Swedish Ministry of Health and Social Affairs and co-financed by the Norwegian Ministry of Health and Care Services.

The report of the investigation explains that alcohol consumption, in a dose-response manner, but especially heavy drinking and alcohol use disorders, increases the risk of contracting infectious diseases such as TB and pneumonia, as well as the progression of TB and HIV. Further, heavy drinking or alcohol use disorders may impair the use of preventive services for infectious diseases and treatment compliance, and may also create risk to others by those already affected. The relationship between alcohol and the risk of infectious diseases can be compounded by poverty, social exclusion, and social mixing patterns, including frequenting specific drinking establishments.

The global picture

The report concludes that globally, alcohol-attributable infectious diseases make up

13.5% of the detrimental impact of alcohol consumption on global mortality. While in absolute terms the disease burden of alcohol-attributable infectious disease is larger for men than women, the proportion of the alcohol impact is fairly similar by gender (mortality: infectious diseases make up 14.1% of the overall detrimental effect for men, and 10.5% for women).

The impact of alcohol consumption on burden of disease and injury is largest in low income countries with relatively high consumption in Saharan Africa or South America, where on average 30% of all the alcohol-attributable burden is due to infectious diseases. In some countries, such as South Africa or Nigeria, infectious diseases make up about 50% of the overall alcohol-attributable disease burden.

In general, even though for low-to middle-income countries, the higher the economic development, the higher the adult per capita consumption, alcohol-attributable mortality and mortality per litre of pure alcohol per capita are highest in countries with the lowest incomes. Part of this relationship, the report suggests, can be explained by the clustering of infectious disease in poor crowded regions, often characterized by malnutrition,

where alcohol's effects on the immune system can be enhanced.

Prevention

In regard to reducing the harm from alcohol, particularly in low to middle income countries, the report says that the implementation of proven, cost-effective policy interventions will reduce the incidence and progression of alcohol-related infectious diseases as well as improving economic and social development.

Focus should be on bringing illicit markets under effective government control, managing the price of alcohol and regulating the availability of alcohol in urban environments. Both general interventions, with the aim to reduce consumption, and, in particular, heavy consumption, and joined up interventions, such as the implementation of brief interventions and other alcohol treatment options integrated within the treatment system for infectious diseases, should be included as part of an integrated alcohol policy package to minimize harm.

In many countries, there will be a need to build public health infrastructures for alcohol policy, including political will and the development of a national alcohol

action plan that deals with the issues of social development and alcohol's role in communicable and non-communicable diseases. Development agencies and philanthropic foundations should provide technical support and aid capacity building to develop, implement, and assess alcohol-control policies and joined up work between communicable diseases and actions on alcohol, supported by stronger international governance for alcohol control.

J. Rehm, P. Anderson, et al: Alcohol, Social Development and Infectious Disease. September 2009.

The report can be accessed at: http://www.se2009.eu/en/meetings_news/2009/9/23/global_expert_meeting_on_alcohol

Global Expert Meeting on Alcohol, Health and Social Development

Speaking at the Global Expert Meeting on Alcohol, Health and Social Development, Zsuzsanna Jakab, Director of the European Centre for Disease Prevention and Control (ECDC), a technical and scientific agency of the EU, addressed the significance of the study on alcohol and infectious disease.

At the start of her speech Mrs Jakab referred to the recent annual report of the UK Chief Medical Officer in which Sir Liam Donaldson pointed out:

“The many people who drink regularly to excess cause damage far beyond their own bodies. Directly and indirectly they affect the well-being and way of life of millions of others.”

Sir Liam used the phrase “passive drinking” to describe the people damaged by the excessive drinking of others. These victims include the drinker's family members and friends, as well as the innocent victims of drink related violence or accidents. Despite the huge harm alcohol causes it is deeply ingrained in our societies and our cultures. Tackling it will require the same sort of integrated, multifaceted public health strategies that have been used against tobacco.

The relationship between alcohol consumption and infectious diseases is a subject that has



Mrs Zsuzsanna Jakab

only recently started to get the attention it deserves.

There were two findings of the study that I found particularly striking:

Firstly, the finding that the global mortality burden of infectious disease (overall 13.5% of the detrimental impact of alcohol) ranks right behind the three categories where alcohol consumption impacts the most: unintentional injuries (23.2%), cardiovascular disease (19.0%) and cancer (17.0%).

Indeed, the mortality burden from infectious diseases is slightly higher than alcohol's mortality burden of liver cirrhosis (13.0%).

The second finding that I found striking was the evidence of multiple pathways – both social and biological – from alcohol consumption to tuberculosis infection. These include increased

risk of infection due to social mixing in drinking environments, and increased risk of progression of the disease. This is because alcohol has both a direct effect on weakening the immune system, and an indirect effect via alcohol related disorders such as malnutrition, cancer and other chronic diseases. Heavy drinking also acts as a barrier for access to treatment and compliance with treatment.

Studies have come to different conclusions about the magnitude of alcohol as a risk factor for tuberculosis. But a study looking at Russia concluded that alcohol was the biggest risk factor for TB there, ahead of both smoking and HIV infection.

The need for an integrated public health approach

Tuberculosis is an excellent case study to look at when examining the link between alcohol and infectious diseases. If we map poverty, substance abuse and infectious diseases in Europe we find they overlap. The poorest members of our society bear a greater burden of disease both from communicable and non-communicable diseases.

As with tuberculosis, so too with many other infectious diseases, alcohol consumption has a number of pathways leading to ill-health, such as weakening the immune system and acting as a pathway to poverty and chronic disease.

Communicable disease experts are only now beginning to investigate and quantify the links between, poverty, alcohol, other kinds of substance abuse and infection.

This needs to be a priority for the coming years, because once one starts to investigate one sees numerous connections.

For example, a proportion of the persons injured because of alcohol will develop wound infections. Some of these infections will be with microbes such as MRSA, which are resistant to commonly used antibiotics. It is likely that, when we start investigating, we will find that alcohol consumption is a factor in nearly all the communicable disease challenges we face.

Alcohol consumption is a determinant that cuts across both communicable and non-communicable diseases. Infectious disease epidemiologists need to be trained to think about alcohol consumption as a factor when investigating trends in communicable diseases. And when looking at health inequalities we must take a holistic approach. We need to look at alcohol's impact on violence, injuries and poverty together with its impact on both communicable and non-communicable diseases.

Role of the ECDC

Our role is to provide high quality data, evidence and advice to health policy makers in the EU Institutions and Member States. We support the policy making process, but ECDC as such does not make health policy. This is a clear difference with WHO.

Evidence of link between alcohol consumption and STIs

The main areas in which we can help are:

Providing the evidence base on the link between alcohol consumption and infectious diseases.

Advising on the types of measures that may be effective in responding to the challenge this presents.

The link between poverty, alcohol and infectious diseases is an area where we need to gather more evidence, and do more investigation.

Another area where we can provide some immediate evidence of alcohol's harmful effects is Sexually Transmitted Infections.

Literature reviews of existing evidence show a link between alcohol use and poor sexual health. One review of 42 studies found that problem drinking is clearly associated with an increased risk of STDs across a wide variety of populations¹.

ECDC's most recent Annual Epidemiological Report showed Chlamydia to be the most frequently reported bacterial infection in the EU and EEA/EFTA countries.

In 2006 nearly a quarter of a million Chlamydia cases were reported in these countries². This is a Sexually Transmitted Infection that mainly affects young people between the ages of 15 and 24 years old.

Willingness to engage in unprotected casual sex is clearly one of the drivers of the relatively high incidence of Chlamydia we are seeing among young people in Europe.

There is evidence from an EU funded³ study that the culture of binge drinking which has taken root among young people in many parts of Europe is a key driving factor in unsafe sexual practices.

Again none of this should surprise us. Alcohol's role in reducing inhibition and impairing judgement has been recognised and exploited by individuals for thousands of years.

Alcohol consumption, particularly heavy use of alcohol, can have negative effects on people living with HIV. It can act as a barrier both to access to treatment and compliance with treatment, thus hastening the onset of AIDS.

There is also a growing body of evidence that alcohol consumption may hasten the onset of liver disease among people living with the Hepatitis C virus.

So what needs to be done about alcohol and infectious diseases?

The response will need to vary from country to country, taking into account differences in culture, social attitudes and health systems. There is not one simple solution.

We all agree that alcohol consumption is one of the key determinants of ill health that needs to be addressed by public health.

Ultimately, though, what Europe needs is an integrated public health strategy to address all

aspects of alcohol related harm. This is something I hope the EU and WHO Europe can work on together.

1. R. L. Cook et al.: Is there an association between alcohol consumption and Sexually Transmitted Diseases? A systematic review", *Sexually Transmitted Diseases*, March 2005
2. 225 996 cases of Chlamydia trachomatis infection were confirmed by 22 EU and EEA/EFTA Member States, giving a rate of 92 per 100 000. Source: ECDC Annual Epidemiological Report 2008
3. Mark Bellis et al Sexual uses of alcohol and drugs and the associated health risks: A cross sectional study of young people in nine European cities, *BMC Public Health* 2008

Doctors call time on alcohol promotion



(BMA) is calling for a total ban on alcohol advertising, including sports events and music festival sponsorship. In addition, the BMA is calling for an end to all promotional deals like happy hours, two-for-one purchases and ladies' free entry nights.

The new BMA report, "Under the Influence" also renews the call for other tough measures such as a minimum price per unit on alcoholic drinks and for them to be taxed higher than the rate of inflation.

Dr Vivienne Nathanson, Head of BMA Science and Ethics, says: "Over the centuries alcohol has become established as (the UK's)

favourite drug. The reality is that young people are drinking more because the whole population is drinking more and our society is awash with pro-alcohol messaging and marketing. In treating this we need to look beyond young people and at society as a whole."

According to the World Health Organization (WHO) alcohol is the leading risk factor for premature death and disability in developed countries after tobacco and blood pressure. It is related to over 60 medical conditions, costs the UK National Health Service millions of pounds every year and is linked to crime and domestic abuse.

In a bid to tackle the soaring cost of alcohol-related harm, particularly in young people, the British Medical Association

Alcohol consumption in the UK has increased rapidly in recent years. For example, household expenditure on all alcoholic drinks increased by 81 per cent between 1992 and 2006. And at the same time, says the author of the report, Professor Gerard Hastings, never before has alcohol been so heavily promoted.



Professor Gerard Hastings

He says: “Given the alcohol industry spends £800 million a year in promoting alcohol in the UK, it is no surprise that children and young people see it everywhere – on TV, in magazines, on billboards, as part of music festivals or football sponsorship deals, on internet pop-ups and on social networking sites. Given adolescents often dislike the taste of alcohol, new products like alcopops and toffee vodka are developed and promoted as they have greater appeal to young people.

“All these promotional activities serve to normalise alcohol as an essential part of every day life. It is no surprise that young people are drawn to alcohol.”

Dr Nathanson maintains that:

“The BMA is not anti-alcohol. As doctors our focus is to ensure that individuals drink sensibly so they do not put their health and lives in danger.

“When the BMA initially called for a ban on smoking in all enclosed public places there were outcries but I doubt most people would want to return to the days of smoky pubs now. This shows that behaviour can change and this needs to happen with alcohol consumption.”

Brand development and stakeholder marketing by the alcohol industry, including partnership working and industry funded health education, has served the needs of the alcohol industry, not public health, says the report.

Dr Nathanson adds: “We have a perverse situation where the alcohol industry is advising our governments about alcohol reduction policies. As with tobacco, putting the fox in charge of the chicken coop – or at least putting him on a par with the farmer – is a dangerous idea. Politicians showed courage before by not bowing to the tobacco industry, they need to do the same now and make tough decisions that will not please alcohol companies.”

Key recommendations from the report include:

- A ban on all alcohol marketing and promotion
- Minimum price levels for the sale of alcoholic products
- Tax increases on alcohol set above the rate of inflation and linked to alcoholic content
- A reduction in licensing hours for on- and off-licensed premises

The report ‘Under the Influence’ can be accessed at: http://www.bma.org.uk/health_promotion_ethics/alcohol/undertheinfluence.jsp



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

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.

Get 'em Young:

Mapping young people's exposure to alcohol marketing in Ireland

Despite the advertising code and the pre-vetting system, young people in Ireland are still exposed to pervasive alcohol marketing through a variety of channels.

This is the main conclusion of a new study by the National Youth Council of Ireland called 'Get'em Young: Mapping young people's exposure to alcohol marketing in Ireland'.

The study questioned groups of young people aged 16 - 19 across the regions of Ireland to get a picture of what kinds of alcohol promotional material they were exposed to and by what means, and what they found appealing about the material.

In total, sixteen different communication channels were

identified by the young people as exposing them to alcohol marketing practices. These were bar/pubs, billboard, bus, cinema, internet, magazines/newspapers, merchandise, music, nightclub, playstation, post, sports stadiums, street flyers, supermarket/shop, and TV.

One in every four of the marketing practices involved a price promotion such as special offers, free alcohol or deep discounts. And of all the practices identified, the majority (60 per cent) were regarded as appealing to the young people, with humour being identified as one of the main bases of the appeal. Eight of the ten most appealing alcohol marketing practices were television advertisements.

1. Carlsberg® Irish language ad (TV)
2. Budweiser® frog ad (internet)
3. Heineken® Rugby ads (in general)
4. Guinness® Drum ad (TV)
5. Bulmers® 'Time dedicated to you' (TV)
6. Corona® - product placement in Heartbreak Kid Film (Film)
7. WKD® ad (TV)
8. Baileys® Crushed Ice ad (TV)
9. Dutch Gold® (Price promotion)
10. Bud Light® ad with man 'wearing' his dog on head (TV)

Top Ten most appealing alcohol marketing practices



Appeal of alcohol marketing to young people

In conclusion, the authors of the report point out that their findings are in direct contradiction of the stated commitment of the Irish government in 2001 to the declaration of the World Health Organization "to minimise the pressure on young people to drink, especially in relation to alcohol promotions, free distributions, advertising, sponsorship and availability, with particular emphasis on special events."

American's Leading Experts on Substance Abuse Outline New Research Agenda to Reduce Multi-Billion Dollar Burden on Health Systems and Society

With substance abuse now accounting for one in 14 hospital admissions in the USA and generating billions in health care costs, leading scientists held a briefing on Capitol Hill to outline the research agenda needed in treating and preventing the use and abuse of alcohol, drugs and tobacco.

Scientists affiliated with the Robert Wood Johnson Foundation's (RWJF) Substance Abuse Policy Research Program (SAPRP) identified steps that federal, state and local governments could take now to reduce the \$2 billion healthcare burden from alcohol, drugs, and tobacco use and abuse. They also provided a roadmap for research over the next five years to deal with future challenges in reducing substance abuse.

A. Thomas (Tom) McLellan, PhD, deputy director of the White House Office of National Drug Control Policy, moderated the briefing.

Policies to Prevent Alcohol Problems:

Harold Holder, PhD, Prevention Research Center, Pacific Institute for Research and Evaluation (PIRE), discussed research exploring prevention, availability and pricing initiatives designed to deter alcohol abuse. He pointed out that currently, federal funding for alcohol prevention programs is dispensed without requiring evidence of a program's effectiveness.

Yet researchers have generated considerable evidence on the effectiveness of policies including minimum drinking ages, a tougher approach to drunk driving, and raising alcohol taxes," he said.

For example, there is evidence that increasing alcohol taxes to keep pace with inflation would lead to a 19 percent reduction in heavy drinking by youth and a 6 percent reduction in high-risk drinking. Research has also shown that simply changing licensing provisions and modifying hours of service at establishments

that sell alcohol can have a significant effect on drinking and drinking-related problems.

"What policymakers need now is research that helps them decide on the best mix of strategies that are likely to be most effective at preventing alcohol problems," he said.

Policies to Prevent Alcohol Problems: A Research Agenda for 2010-2015

Holder and his colleagues suggest that the research agenda for alcohol prevention should be viewed within the context of the "prevention paradox." This is the paradox that while alcohol dependent persons have the highest individual risk of alcohol problems, it is moderate and heavy nondependent drinkers who account for more total alcohol problems, especially those of an acute nature, because there are so many more of them. Therefore, a much wider public health perspective than alcohol dependence is essential for policy research, and the new identification of research priorities has therefore focused on alcohol-involved problems or high-risk drinking where the individual drinkers have not been identified by the recovery, treatment, or health screening systems. The biggest future challenge for alcohol policy research, the authors say, is population-level alcohol problem prevention (a public health perspective).

The research agenda identifies five main themes for alcohol prevention policy research from 2010 to 2015 . While many priorities exist and much more needs to be understood about the effectiveness of specific alcohol policies, the alcohol policy research priorities cited here reflect new or under-developed areas of research that are judged to be highly relevant to needed policy change.

They are organized into domains identifying the highest alcohol policy research priorities at the international, national, state, provincial, and community levels.

- I. International Trade Agreements
- II. National/State/Provincial/Community Prevention
- III. Retail Price of Alcohol
- IV. Physical Availability of Alcohol
- V. Prevention of Intoxication and Over-Service of Alcohol

The full report can be accessed at: <http://saprp.tumblr.com/>

Is alcohol protection for the heart exaggerated?

The idea that alcohol in moderation is good for you is being subjected to increasingly critical scrutiny. A recent issue of the online New Zealand Medical Journal contained a number of papers in which clinicians raised question marks over the protective effect for the heart of drinking moderate daily amounts of alcohol. The title of one of the papers was 'For public health doctors, alcohol is the new tobacco'.

The writers of a paper on alcohol and the heart concluded that cardio-protection from alcohol is by no means certain and probably has been over-emphasised in recent years.

"When viewed through the lens of two major early reviews in the mid-1980's, then Sir Richard Doll's contributions in the mid 1990s, followed by two large meta-analyses a decade ago and two most recent overviews, the health giving properties of alcohol use becomes increasingly debateable," says one of the authors Professor Doug Sellman. Professor Sellman is Director of the National Addiction Centre at the University of Otago, Christchurch.

The writers raise the issue of the influence of the alcohol industry in some of the studies reviewed in relation to the exaggeration of positive effects on the heart and health generally.

They also point out that there are many other health downsides from heavy drinking, and that alcohol is now widely recognised as New Zealand's most dangerous recreational drug.

The article stresses it is important to remember that the two major early reviews of the vast amount of literature on this subject came to opposite conclusions regarding alcohol's protective effect on coronary heart disease (CHD). However, Sir Richard Doll's sample of 34,000 UK doctors came down on the positive side of the argument.

The two meta-analyses a decade ago also equivocated. One said that alcohol reduces risks of CHD through changes in lipids and haemostatic factors, while the other said that the degree of protection from moderate drinking should be reconsidered and further research is needed.

Finally two recent overviews have also raised more doubts. An editorial in *The Lancet* said the benefits of light drinking have been over-estimated and warned of the health downsides of heavier drinking; increased blood pressure, risk of stroke, and risk of breast cancer increased by 9% for every additional standard drink.

"Essentially we believe that alcohol is still potentially a dangerous drug which can cause a range of acute and chronic health problems, so should not be promoted by anyone as a health tonic," say the writers of that article.

Thai Youth protest at International Center for Alcohol Policy attempt to interfere in Thai Policy

Using the pretext of the WHO resolution on strategies to reduce alcohol related harm the International Center for Alcohol Policy (ICAP) approached the Thai Prime Minister and Health Minister to see how ICAP could help the Thai Government to reduce alcohol related harm in Thailand. Concerned over such interference in Thai alcohol policy, a protest demonstration was organised by the Stop Drink Network. The Stop Drink Network is a large youth network having contacts with 350 organisations nationwide.

ICAP is funded by many of the major global alcohol companies. The total budget for ICAP in 2007 was \$2.65 million.

The 2007 financial accounts submitted to the United States Inland Revenue show that ICAP allocated \$237,000 (Two hundred and Thirty Seven Thousand Dollars) for activities in Asia. Their report states that the allocated sum is “to position ICAP and its activities in the Asia-Pacific Region so that ICAP is seen as a regional as well as a global resource”.

An allocation of \$218,644 (Two Hundred and Eighteen Thousand Six Hundred and Forty Four US Dollars) was also made for a regional workshop on self-regulation “to strengthen regional commitments and systems of self regulation by exchanging best practices in self-regulation with a wide range of stakeholders from the governmental, public health and beverage alcohol industry sectors.”

Alcohol consumption rate among Thai population has been rapidly increasing. Consumption of alcohol is particularly common among males. However between 1996 and 2003 consumption among girls aged from 15-19 years rose almost six times. Advocacy by Thai Health helped persuade the Thai cabinet to pass a resolution in July 2003 to ban advertisements of all beverages with more than 0.5% alcohol on radio and TV broadcast between 5am and 10pm.

Thai Health has funded activities carried out by alcohol control organizations in Thailand. For instance, it has paid for major advertising campaigns to reduce alcohol-related traffic accidents at Thai New Year; to encourage abstinence from alcohol during Buddhist Lent; to raise awareness about the links between alcohol and domestic violence; and to reduce the number of new drinkers. It has provided funding to replace sponsorship by the alcohol industry.

Diageo and ICAP

Diageo and ICAP at a London press conference in November 2009 launched their book “Working together to Reduce Alcohol Related Harm”, aimed at policy makers and particularly those that will decide WHO strategy. Paul Walsh, Chief Executive of Diageo, is reported as saying, “Granted, we have views about the efficacy of increasing prices or banning marketing... but we also offer a slate of areas where alcohol producers could be involved”. Walsh also spoke of ‘extremists’ among public health campaigners lobbying against drinks industry involvement in the strategy debate.

Derek Rutherford, Chair of GAPA comments: “There is a role for industry to market its product responsibly; to comply with national rules and regulations; to provide training for those who sell and serve alcohol and to prevent their clientele from over indulgence or inappropriate drinking patterns such as drinking and driving. However, NGOs do adhere to the 2001 WHO European Ministerial Conference Declaration “*Public health policies concerning alcohol need to be formulated by public health interests without interference from commercial interests*”.

See also the Globe Issue 3 2002 “The Beverage Alcohol Industry’s Social Aspect Organizations – a public health warning”. Website: http://www.ias.org.uk/resources/publications/theglobe/globe200203/gl200203_p6.html



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