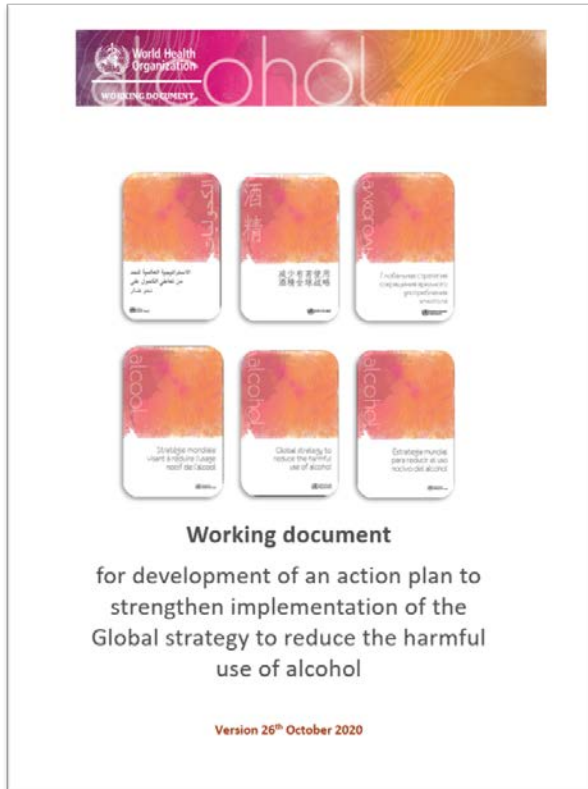


Development of an action plan (2022-2030) to effectively implement the WHO Global strategy to reduce the harmful use of alcohol



This document contains 254 submissions received in a web-based consultation on a working document for development of an action plan (2022-2030) to effectively implement the WHO Global strategy to reduce the harmful use of alcohol.

RECEIVED SUBMISSIONS FROM A WEB-BASED CONSULTATION ON THE WORKING DOCUMENT

Volume I

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Background

The harmful use of alcohol causes approximately 3 million deaths every year and the overall burden of disease and injuries attributable to alcohol consumption remains unacceptably high. The pace of development and implementation of alcohol policies has been uneven in WHO regions, and resources and capacities for implementation of the WHO Global strategy to reduce the harmful use of alcohol 10 years after its endorsement do not correspond to the magnitude of the problems. On this basis, the WHO Executive Board in its decision [EB146 \(14\)](#) called for accelerated action to reduce the harmful use of alcohol.

The Board considered the [report on the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases](#), particularly Annex 3, entitled “Implementation of the global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward”, and [the report on the findings of the consultative process on implementation of the global strategy to reduce the harmful use of alcohol and the way forward](#).

The Board, in its decision [EB146 \(14\)](#), requested the WHO Director-General, inter alia, “to develop an action plan (2022-2030) to effectively implement the [Global strategy to reduce the harmful use of alcohol](#) as a public health priority, in consultation with Member States and relevant stakeholders, for consideration by the 75th World Health Assembly through the 150th session of the WHO Executive Board in 2022”, and “to develop a technical report on the harmful use of alcohol related to cross-border alcohol marketing, advertising and promotional activities, including targeting youth and adolescents, before the 150th session of the WHO Executive Board, which could contribute to the development of the action plan”, as well as “to adequately resource the work on the harmful use of alcohol. As part of its response to decision EB146 (14), the WHO Secretariat conducted a [Web-based consultation](#) from 16 November to 13 December 2020 on a [working document for development of the action plan](#) open to Member States, UN organizations and other international organizations, and non-State actors.

In the process of the web-based consultation the participants had the option to either submit a full response online or submit an abstract online and attach the full submission as pdf or doc file. Several participants decided to both do a full submission online and attach a file with the same submission. Attachments to full submission that has not been produced directly for the consultation or contain general information, webpages or public documents have been removed. The submissions have not been edited.

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Overview of received submissions to the web based consultation

ACT Health Promotion

Actis - Norwegian policy network on alcohol and drugs

Advertising Information Group (AIG)

AlcoHELP

Alcohol Action Ireland

Alcohol Action NZ

Alcohol and Drug Foundation

Alcohol and Drug Information Centre

Alcohol Beverages Australia

Alcohol Control Policy Network

Alcohol Focus Scotland

Alcohol Health Alliance UK

Alcohol Healthwatch

Alcohol Justice

Alcohol Policy Futures

Alko

American Public Health Association

Anti Drug Abuse Association of Lesotho (ADAAL)

APN (Alcohol Policy Network in Europe)

Asia Pacific Alcohol Policy Alliance

Asociación Prolicores

AssoBirra

Association des Guides du Rwanda

Association for Prevention of Alcohol Misuse (APAM)

Association of Advocates against Alcohol Harm in Nigeria

Associazione Italiana Disordini da Esposizione Fetale ad Alcol e/o Droghe (AIDEFAD - aps)

Aston Kuseka Innovations (A.K.Innovs)

AUCKLAND REGIONAL PUBLIC HEALTH SERVICE

Austrian Economics Center

Balance

Beer Canada

Belgian Brewers

Bendukidze Free Market Center

Blue Cross Kisumu - Kenya
Brazilian Institute of Cachaça - IBRAC
Brazilian National Beer Chamber – Ministry of Agriculture, Livestock and Supply
Brewers Association of Australia
Brewers of Romania Association
British Beer and Pub Association
Bundesverband der Deutschen Spirituosen-Industrie und -Importeure e. V. (BSI)
Burundi alcohol Policy Alliance
CADCA
California Alcohol Policy Alliance
Cámara de Comercio de Lima
CAMARA NACIONAL DE LA INDUSTRIA DE TRANSFORMACIÓN (CANACINTRA)
Cámara Nacional de la Industria Tequilera
Canadian Centre on Substance use and Addiction
CEEV, Comité Européen des Entreprises Vins
Center for Indonesian Policy Studies
Center for Law and Policy Affairs
Center for youths mental health and drug abuse prevention Nigeria
Cerveceros de España
Chamber of Agricultural and Food Enterprises, Chamber of Commerce and Industry Slovenia
CHU de La Réunion
Civil Development Forum
Clinique Belmont Genève
COALICIÓN MÉXICO SALUD-HABLE
COMISION PARA LA INDUSTRIA DE VINOS Y LICORES AC
Committe for alcohol regulation - Brazil
Confederación Patronal de la República Mexicana (COPARMEX)
Consejo Nacional Agropecuario, Asociación Civil
Crisis Resolving Centre
Dalgarno Institute
Directorate of Health
Distilled Spirits Council of the U.S.
Drinkaware

Drinks Ireland
DrinkWise Australia
Dutch Institute for Alcohol Policy STAP
EASL
Educ'alcool
Epicenter
European Alcohol Policy Alliance - Eurocare
European Commission
European Fetal Alcohol Spectrum Disorders Alliance
European Mutual help Network for Alcohol related problems
(EMNA) European Network of Teratology Information Services
(ENTIS) European Public Health Alliance
Fascinating children
FASD Network UK
FASD Okanagan Valley Assessment and Support Society
FEDERACION ESPAÑOLA DEL VINO - FEV
Federvini
Finnish institute for health and welfare
FIVS
Foro Regulación Inteligente
FORUT and partner organisations
Foundation for a Drug-Free World (Nigeria)
Foundation for Alcohol Research and Education (FARE)
Foundation for Innovative Social Development (FISD)
Foundation for Rural and Urban Transformation (FoRUT) Foundation
for Social Welfare Services
Foundation for the Advancement of Liberty
Fourth Wave Foundation
Free Market Foundation
Free Trade Europa
Freedom Research Association
French Association of Wine and Spirits Exporters (FEVS)
Fundación Civismo
FUNDACIÓN DE INVESTIGACIONES SOCIALES A.C.

Fundacion Saber Beber
Glasgow Caledonian University
Global Alcohol Policy Alliance
green crescent of congo democratic
Green Crescent South Africa
Government of Japan
Hāpai te Hauora
Health Canada
Health Coalition Aotearoa
Health Services Executive
Healthy Caribbean Coalition
Healthy Lanka
Heartland Alliance International
Hellenic Association of Brewers
Hong Kong Alliance for Advocacy Against Alcohol
House of Hilkiyah Foundation
Independent Order of True Templars (I.O.T.T)
INESS Institute of Economic and Social Studies
Institut économique Molinari
Institute for Research and Development "Utrip"
Institute of Alcohol Studies
Institute of Economic Affairs
Instituto Juan de Mariana
Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz
Instituto Nacional de Vitivinicultura
International Alliance for Responsible Drinking
International Confederation of ATOD Research
Associations International Council for Advertising Self-
Regulation International Council of Nurses
International Council on Alcohol and Addictions
IOGT Iceland
IOGT-NTO
IOGT-NTO Movement
IOGT-VN

Istituto Bruno Leoni

ISTITUTO SUPERIORE DI SANITA'

Japan Spirits & Liqueurs Makers Association (JSLMA)

Joint Submission of NCD Alliance, Vital Strategies, UICC, World Heart Federation,

World Obesity Federation and Movendi International

Kenya Association of Muslim Medical Professionals (KAMMP)

Khmer Youth Association

KoRus Sør, Kompetansecenter rus region sør (A norwegian resource centre for drug and alcohol problems)

Kookiri ki Taamakima Bureau Trust

L.K. Advocates

Latvian Public Health Association

Liberální Institut

Libertania

Liberty Sparks

Lithuanian Tobacco and Alcohol Control Coalition

Massey University

Mexican National Beer Chamber

Ministerio de Salud de la Nación Argentina

Ministerio de Salud Pública, Dominican Republic

Ministerio de salud y Protección social, Colombia

Ministry of Health (Spain)

Ministry of Health, Turkey

Ministry of Health, Chile

Ministry of Health, Welfare and Sport, The Netherlands

Ministry of Social Affairs and Health, Finland

Movendi International

Movendi International Member organization, Population Health Research Center Mongolia

Movendi Slovakia

Nada India Foundation

National Alliance for Action on Alcohol

National Drug Research Institute

NCD Alliance

Nederlandse Brouwers
Nepal Alcohol Policy Allianc
Nepal Health Society
New Zealand College of Public Health Medicine
New Zealand Medical Association
NordAN
Norwegian Cancer Society
OIV
People Against Drug Dependence and Ignorance
Pernod Ricard
Polish Brewers Association - ZPSB Browary Polskie
Polish Spirits Industry
Polish Vodka Association
Portman Group
Portuguese Brewers Association
Prevention Network/Michigan Coalition to Reduce Excessive Drinking and Michigan Alcohol Policy
Promoting Health and Safety
Project Extra Mile
Prometheus - Das Freiheitsinstitut
Public Health Agency of Catalonia / Department of Health / Government of Catalonia
Queensland Coalition for Action on Alcohol
Recover Alaska
Regional Beverage Alcohol Alliance
RIVLAS - Representantes e Importadores de Vinos y Licores Asociado
Ruffino srl
Russell Family Fetal Alcohol Disorders Association
SAAPA Botswana
SAAPA Namibia
SAAPA Zimbabwe
SALBA, BASA and Vinpro
Scottish Alcohol Research Network (SARN)
Scottish Families Affected by Alcohol & Drugs
SCOTTISH GOVERNMENT

Scottish Health Action on Alcohol Problems (SHAAP)
Scottish Recovery Consortium
Sierra Leone Alcohol Policy Alliance (SLAPA)
SIFASD, Società Italiana sulla Sindrome Feto-Alcolica
Sindicato Nacional da Indústria da Cerveja
Sober World
SOUTHERN AFRICAN ALCOHOL POLICY ALLIANCE- LESOTHO CHAPTER
Southern African Alcohol Policy Alliance
Southern African Alcohol Policy Alliance South Africa (SAAPA SA)
Spirits New Zealand/Brewers Association of New Zealand/New Zealand Winegrowers
spiritsBULGARIA
spiritsEUROPE
Sri Lanka Alcohol Policy Alliance (SLAPA)
STIVA (Stichting Verantwoorde Alcoholconsumptie)
Stop Drink Network,
Systembolaget AB
Tairawhiti Community FASD Working Group
Tanzania Network Against Alcohol Abuse - TAAANet
Teesside University, INEBRIA
Texans for Safe and Drug-Free Youth
Thai Health Promotion Foundation
The Alcohol and Families Alliance
The Brewers of Europe
The Cancer Society of New Zealand
The Government of the Hong Kong Special Administrative Region
The National Organisation for FASD (UK)
The Scotch Whisky Association
Turkish Green Crescent
U.S. Alcohol Policy Alliance
UK FASD Research Collaboration
UK Government
University of The Basque Country
Union for International Cancer Control
United European Gastroenterology

Universidad del Bío-Bío

University of Exeter

University of York Transformative Research on Alcohol Policy and Science programme

Value Health Africa

Visio Institut

VISUAL TEAF

Vital Strategies

West Indies Rum & Spirits Producers Association (WIRSPA)

Winooski Partnership for Prevention

World Cancer Research Fund International

World Federation of Advertisers

World Heart Federation

WORLD MEDICAL ASSOCIATION

World Spirits Alliance

Worldwide Brewing Alliance

Yale School of Medicine

Young Power in Social Action (YPSA)

Youth against Alcoholism & Drug Dependency

Youth for Development and Human Rights Advancement

ZERO SAF

Volume III

ACT Health Promotion

Country/Location: Brazil

URL: <https://actbr.org.br/>

Submission

There are many laudatory aspects in the consultation document, but ACT would also like to point out some of general concern. It is our understanding that tackling these main aspects would strengthen the document, as well as the possibilities of implementing truly effective policies to regulate the harmful use of alcohol, a growing public health problem.

Attachment(s): 1

00371_34_who-consultation-alcohol-act-2.pdf

Response to WHO ‘Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol’ from ACT Health Promotion

11 December 2020

ACT Health Promotion is a non-profit organization working in Brazil that contributes with advocacy for public policies oriented at the prevention of NCDs and at the promotion of healthy lifestyles¹.

ACT was founded in 2006 with the aim of working for public policies in tobacco control, following the recommendations of the Framework Convention on Tobacco Control (WHO FCTC). In 2014, ACT also started working on the prevention of other noncommunicable diseases, promoting healthy and adequate diets, the control of alcohol use, as well as physical activity. ACT's main focus is to promote advocacy and public policies aimed at creating healthy environments that, in turn, promote healthy choices.

Over the years, ACT has contributed with important advances in public health in Brazil and the organization aims to continue doing so by strengthening civil society capacity to advocate for the full implementation of the Brazilian Strategic Action Plan to tackle NCDs, as well as improving capacity to link global commitments with national goals, supporting strong international commitments for public health and sustainable development.

ACT represents NCD Alliance in Brazil² and has a network of over 1000 members (“Rede ACT”) from the five different regions in the country, working with the main NCD risk factors. ACT is also on the board of the Committee for Alcohol regulation (CRA) in Brazil³. Advancing as a civil society alliance is important to promote the adoption of effective policies to regulate the consumption of unhealthy commodities, such as alcohol.

Introduction

ACT was very pleased to know of the working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol and the open consultation regarding its content.

¹ <https://actbr.org.br/>

² <https://ncdalliance.org/act-promoção-da-saúde>

³ <https://femsantacasasp.edu.br/cra/>

The harmful use of alcohol represents a major public health challenge. Alcohol consumption contributes to 3 million deaths each year globally as well as to the disabilities and poor health of millions of people. Overall, harmful use of alcohol is the leading risk factor related to the major burden of disease in low mortality developing countries and the third most prevalent risk factor for leading diseases and injuries in developed countries (WHO, 2002). It is responsible for 5.1% of the global burden of disease. Disadvantaged and especially vulnerable populations have higher rates of alcohol-related death and hospitalization.⁴

Data on alcohol exposure indicate that between 1990 and 2017 global adult per-capita consumption increased from 5.9 L to 6.5 L and is projected to continue rising⁵, particularly so in middle income countries, such as those in Latin America⁶. In general, low- and middle-income countries (LMICs) still do not many of the effective alcohol policies enumerated by the global strategy in place.⁷

The results of the harmful use of alcohol relate to disease, but also to social and economic burden in societies. The need for effective policies in this regard is, therefore, specifically mentioned in target 3.5 of the 2030 Agenda for Sustainable Development, which states that countries should “strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.”⁸

Despite the accumulated knowledge and advocacy efforts of international organizations, civil society and academia, after 10 years of the global action plan, unfortunately results are still inadequate. ACT therefore welcomes the opportunity for diverse groups to collaborate with this working document, via consultation, and hopes that this will create momentum to push forward effective policies in the near future.

Contributions

There are many laudatory aspects in the consultation document, but ACT would also like to point out some of general concern. It is our understanding that tackling these main aspects would strengthen the document, as well as the possibilities of implementing truly effective policies to regulate the harmful use of alcohol, a growing public health problem.

⁴ https://www.who.int/health-topics/alcohol#tab=tab_1

⁵ Manthey J, Shield KD, Rylett M, Hasan OSM, Probst C, Rehm J. Global alcohol exposure between 1990 and 2017 and forecasts until 2030: a modelling study. *The Lancet* 2019;393:2493-502.

⁶ World Health Organization. Global status report on alcohol and health 2018. Geneva. 2018. <http://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1>.

⁷ WHO. Global status report on alcohol and health 2018. Geneva: World Health Organization, 2018.

⁸ <https://unstats.un.org/sdgs/metadata?Text=&Goal=3&Target=3.5>

(a) Role of economic operators

Considerable challenges remain for the development and implementation of effective alcohol policies, one of the main ones being the influence of powerful commercial interests in policy-making and implementation.

In the working document, “economic operators”, or alcohol industry entities, are seen as stakeholders in equal standing alongside civil society and other UN organizations in order to reduce the harmful use of alcohol. This is particularly dangerous, seeing that the alcohol has inherent conflict of interest and a history of undermining effective alcohol policies. The alcohol industry should, instead, be addressed in a separate section with due regard to conflict of interest toward safeguarding public health.

History teaches many important lessons. A story of success in public health relates to tobacco control, and the WHO FCTC plays a big part in this. Especially, Article 5.3 has been fundamental. It states that in “setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law”⁹.

The importance of vigorous implementation of FCTC Article 5.3, which insulates public health policymaking from industry interference, cannot be undermined. The FCTC provides guidelines¹⁰ to implement this article that should serve as inspiration to alcohol control initiatives.

RECOMMENDATIONS

Measures for protecting public health policies with respect to alcohol control from commercial and other vested interests of the alcohol industry are listed below, drawing for the experience of tobacco control policies:

(1) Raise awareness about the addictive and harmful nature of alcohol and about alcohol industry interference with alcohol control policies. (2) Establish measures to limit interactions with the alcohol industry and ensure the transparency of those interactions that occur. (3) Reject partnerships and non-binding or non-enforceable agreements with the alcohol industry. (4) Avoid conflicts of interest for government officials and employees. (5) Require that information provided by the alcohol industry be transparent and accurate. (6) Denormalize and, to the extent possible, regulate activities described as “socially responsible” by the alcohol industry, including but not limited to activities described as corporate social responsibility (CSR). (7) Do not give preferential treatment to the alcohol industry.

⁹ https://www.who.int/tobacco/wntd/2012/article_5_3_fctc/en/

¹⁰ https://www.who.int/fctc/guidelines/article_5_3.pdf

It is also important to raise awareness about the addictive and potentially harmful nature of alcohol use. All branches of government and the public need knowledge and awareness about past and present interference by the alcohol industry in setting and implementing public health policies with respect to alcohol control.¹¹ The alcohol industry, as the tobacco industry, has a bleak record of employing ethically questionable tactics to influence decision makers and prevent the implementation of effective regulation measures that aim to safeguard the health of the population.

“In the view of WHO, the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.”

Dr. Margaret Chan, former Director General of World Health Organization (quoted in Gornall, 2013)

(b) Focus on best buys/SAFER

It is our opinion that the working document should, for communications and strategic purposes, focus on the most cost-effective and science-based policies to reduce alcohol-related harms. Following the successful example of MPOWER for tobacco control and other WHO technical packages, SAFER provides action-oriented guidance for country-level implementation with a small number of high-impact interventions according to the SAFER guidance: (i) Strengthening restrictions on alcohol availability; (ii) Advancing and enforcing drink driving counter measures; (iii) Facilitating access to screening, brief interventions, and treatment; (iv) Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship, and promotion; and (v) Raising prices on alcohol through excise taxes and pricing policies.

(c) Advocacy/Implementation

Advocacy, resource mobilization, technical capacity building and programmatic action at country level should be considered key components in the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol’.

¹¹ In this regard, see:

https://ncdalliance.org/sites/default/files/resource_files/NCDAlliance_Alcohol%20Control%20report%20in%20LAC_English_0.pdf

Since the adoption of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) in 2003, public health and advocacy professionals have debated similar conventions covering other health risks, including potentially a Framework Convention on Alcohol Control. ACT believes that the merits of advocating (and implementing) a legally binding instrument would be extremely beneficial, for commitments at both national and international levels.

(d) Monitoring

The implementation of effective alcohol policy regulations must be supported by strong monitoring systems, to enable accountability and progress tracking. Such systems should include monitoring of sales, consumption, health and social harms, economic impact, and industry practices.

Prior to the review of the SDGs and Action Plan in 2030, a progress report and recommendations for the way forward for reducing alcohol harm through alcohol policy should be submitted to the WHO governing bodies by 2028 at the latest to ensure there is no further delay to proportionately addressing any persistent barriers to progress identified through the course of the Action Plan.

Actis - Norwegian policy network on alcohol and drugs

Country/Location: Norway

URL: www.actis.no

Submission

Actis – Norwegian policy network on alcohol and drugs is an umbrella organisation for Norwegian NGOs in the alcohol and drugs field. We currently represent 34 member organisations, ranging from youth organisations to treatment providers and recovery groups, as well as ethnic and sexual minorities. Our mission is to advocate for alcohol, drug and gambling policies that protect the health and well-being of individuals and communities.

Introduction

We thank the WHO for the opportunity to provide input to the working document of the Action plan to reduce the harmful use of alcohol. We believe the action plan will be an important next step in the global work to reduce alcohol related harm.

We note with concern the fact that alcohol consumption has not decreased over the past decade, despite the endorsement of the Global Strategy in 2010.

Since then, several regional and global documents have reinforced the commitment to reducing alcohol related harm. The NCD-strategy from 2013 identifies alcohol as one of the four leading risk factors for non-communicable diseases and sets out a goal to reduce alcohol consumption by 10 percent. Furthermore, the global commitment to reducing alcohol related harm is reflected in Sustainable development goal 3.5. Alcohol also directly impacts on the goals of reducing non-communicable diseases (3.4) and road traffic accidents (3.6).

We agree with the analysis that implementation and enforcement of the Global Strategy has been uneven. There is therefore an urgent need for an action plan that outlines concrete steps to reach the agreed targets.

Focus on implementation

While written alcohol strategies and plans are important, they have little impact if policies are not implemented and enforced. We therefore welcome target 1.1 that focuses on implementation and enforcement of high impact policies.

Legally binding instrument

We appreciate the comment on the lack of a legally binding instrument in international alcohol policy. This represents an anomaly in the global approach to addictive substances, which already has three binding drug conventions and a framework convention on tobacco control. In light of an increasingly global and digital alcohol market, we think it is time to discuss the feasibility and utility of such a legally binding document in the field of alcohol policy.

Alcohol related harm

The evidence on the harms of alcohol has grown over the past decade. One area where the evidence is stronger now than in 2010 is the link between alcohol and cancer. This is mentioned very briefly in the chapter on “Opportunities for reducing the harmful use of alcohol,” but this is an important point that could be further elaborated.

The paragraph on the harms of alcohol should also include Foetal Alcohol Spectrum Disorders. Furthermore, driving under the influence of alcohol is a major risk factor for traffic accidents and fatalities. Reducing drink driving is key to achieving the sustainable development goal of reducing road traffic injuries and fatalities. This link should be mentioned as one of the leading harms of alcohol.

Despite the encouraging trend of lower alcohol consumption among youth in the past decade, it is also worth pointing out the disproportionate impact of alcohol on young people.

The contribution of alcohol to social inequalities in health is an important public health issue. The role of high impact alcohol policies in reducing health inequalities should therefore be highlighted.

High impact policies

The evidence shows that alcohol related harm is associated with population drinking, and that population drinking is also related to high risk drinking. Policies that reduce population drinking are therefore also effective in reducing alcohol related harm and harmful drinking.

It is important that the action plan focuses on the high impact policies outlined in the “Best buys” and the SAFER initiative. We therefore support the targets for Action area 1 that focus on implementation of high-impact policies and population drinking levels.

We share the concern about alcohol marketing that targets young people and adolescents. However, it is not always possible to prove that marketing targets minors, and in many cases marketing that is not specifically targeted at minors will still appeal to young people. We therefore think that it is more appropriate to talk about reducing exposure to marketing.

We also agree that everyone should be protected from pressures to drink. However, we believe that the strategy should not just address direct pressures to drink, but also wider social norms that promote drinking.

The role of Non-State Actors

Civil society organisations can play a key role in raising awareness of alcohol related harm, advocating for high impact alcohol policies and holding economic operators as well as governments accountable for their actions and in-actions. We welcome the commitment of the WHO to strengthen the role of civil society organisations.

We agree that there is an inherent conflict of interest between economic operators and public health. Nevertheless, economic operators are mentioned as stakeholders along with civil society organisations and other UN bodies.

We agree with Eurocare that the economic operators should be addressed separately and in a way that recognizes the potential conflicts of interest. We would also like to echo the request from the Global

Alcohol Policy Alliance to strengthen the Framework for Engagement with Non-State Actors and include specific references to the conflicts of interests of the alcohol industry.

The role of the regional offices

The document does not outline the collaboration between the WHO secretariat and the regional offices or other regional bodies. In some cases, policy issues may be best handled on the regional level. Cross-border issues may undermine national alcohol policies. The solution is cooperation between countries in the same region, not necessarily global agreements. The role of regional offices should be more clearly outlined in the final version.

Attachment(s): 0

Advertising Information Group (AIG)

Country/Location: United Kingdom of Great Britain and Northern Ireland

URL: <https://www.adassoc.org.uk/our-work/advertising-information-group/>

Submission

Please see document attached for full response.

Summary as follows:

The Advertising Information Group (AIG) supports the principle that alcohol should be consumed in moderation and responsibly. However, any measures to restrict alcohol advertising need to be evidence-based and proportional. Implementing bans or comprehensive restrictions on alcohol advertising would impact more widely on the advertising, culture, media and sports industries that rely on advertising and sponsorship for their revenues.

According to research, advertising bans to reduce the consumption of alcohol have produced mixed, inconclusive or even-counterproductive results. Measures such as bans or additional taxation on advertising leads to advertisers exploring the use of alternative marketing techniques to make their product more appealing to consumers, such as price reductions and other promotions.

Finally, the WHO's proposals do not consider existing rules set out within the advertising self-regulatory system and how its effectiveness could be leveraged to help the WHO achieve its stated aims.

Attachment(s): 1

00345_20_20201211-aig-response-to-who-consultation.pdf

AIG response to WHO consultation on its working document for the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Summary

We support the principle that alcohol should be consumed in moderation and responsibly. However, any measures to restrict alcohol advertising need to be evidence-based and proportional. Implementing bans or comprehensive restrictions on alcohol advertising would impact more widely on the advertising, culture, media and sports industries that rely on advertising and sponsorship for their revenues.

According to research, advertising bans to reduce the consumption of alcohol have produced mixed, inconclusive or even-counterproductive results. Measures such as bans or additional taxation on advertising leads to advertisers exploring the use of alternative marketing techniques to make their product more appealing to consumers, such as price reductions and other promotions.

Finally, the WHO's proposals do not consider existing rules set out within the advertising self-regulatory system and how its effectiveness could be leveraged to help the WHO achieve its stated aims.

About the Advertising Information Group

The Advertising Information Group (AIG) is a European advertising and media industry network that brings together different parts of the advertising industry, from advertising agencies to broadcaster and publisher bodies, direct marketing, radio and online.

Three national advertising associations: the UK's Advertising Association, the German Advertising Federation (ZAW), and the Austrian Advertising Association (WKO) act as the Secretariat for the Group.

If there are any questions regarding the points raised in our submission, please contact edward.Butler@adassoc.org.uk.

Our response

The Advertising Information Group (AIG) would like to express our concern over proposals included in the WHO's working document, namely:

- Action area 1: for Member States to prioritise and implement policy options recommended in the WHO SAFER technical package, which recommends enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion.
- Action area 2: which invites economic operators to take steps towards eliminating the marketing and advertising of alcoholic products to minors, whilst refraining from promoting drinking and preventing any positive health claims; and
- Action area 6: which recommends taxing alcohol advertising to fund health-promotion initiatives.

The WHO's proposals ignore the role that advertising self-regulation and co-regulation plays in setting and enforcing standards of responsible advertising. For example, Advertising Codes ensure that alcohol advertising is directed away from children and reduce the exposure of vulnerable groups and minors to such advertisements. Advertising self-regulation is well established across Europe and the world and is an efficient and cost-effective way of regulating the market. Implementing bans or comprehensive restrictions on alcohol advertising would impose unnecessary and damaging costs to the advertising industry. Moreover, it would affect the revenues of important sectors such as culture, media and sports that rely on advertising and sponsorship. According to research, advertising bans to reduce the consumption of alcohol have produced mixed, inconclusive or even-counterproductive results.

Academic studies suggest that bans on advertising do not necessarily decrease alcohol consumption. One study found that the elimination of an advertising ban on price advertising in Rhode Island had no impact on the distribution of prices¹. In other studies, alcohol consumption has been shown to be more closely correlated with socio-economic factors in developed countries, such as levels of unemployment, tourism, ageing population and cultural attitudes towards alcohol², and therefore, we question the efficacy of an advertising ban or further restrictions. For example, Mediterranean wine drinking countries, which were found to have fewer restrictions on alcohol advertising, had lower consumption levels than Nordic spirits drinking countries, which had tighter restrictions, including an outright ban on alcohol advertising in print media. Other interventions around physical availability and drink driving laws were found to be more effective policies.

Regulatory interventions such as bans or additional taxation on advertising will not only have negative effects on the advertising and media industries but could be counter-productive towards achieving the WHO's stated goals.

In many countries, alcohol is already heavily taxed, and the revenues collected are supposedly used by governments to fund health initiatives. The tax is borne by the consumer and therefore, economically speaking, the consumer is already paying for any negative externalities that might be caused by its consumption. However, we remain unconvinced that an advertising ban or an advertising tax would make a material difference to public health initiatives. It would just unfairly penalise the advertising and media industries.

We ask the WHO to take account of the advertising self-regulation codes that are in operation in many countries to protect vulnerable groups and minors from exposure to inappropriate advertising content, as well as promoting responsible alcohol consumption. The 2022-2030 Action Plan being proposed to Member States could recommend working in conjunction with national advertising self-regulatory organisations (SROs), members of the International Council for Advertising Self-Regulation (ICAS) and the European Advertising Standards Alliance (EASA), to develop policy options in this area. Responsible advertising and marketing communications for alcohol beverages is a key priority for the advertising industry and SROs. SROs enforce robust and effective national programmes and standards which reflect the principles of the [Marketing and Advertising Code of the International Chamber of Commerce](#) and its related framework, the [ICC Framework for Responsible Marketing Communications of Alcohol](#).

¹ Saffer H. (2010). Evaluating econometric studies of alcohol advertising. National Bureau of Economic Research, Journal of Studies on Alcohol and Drugs/ Supplement No 19, pg 106-112.

² Jon P.Nelson, "Alcohol advertising bans, consumption and control policies in seventeen OECD countries, 1975-2000". (2010), pages 17-19.

In Europe, advertising self-regulation complements statutory regulation. For example, the revised Audio-visual Media Services Directive (AVMSD) encourages self-regulation and the use of codes of conduct in relation to alcohol marketing³. The European Union's Better Regulation package⁴ also commends principles for effective self-regulation and its inclusion in the policy toolkit and regulatory impact assessment.

Regarding the protection of minors, national advertising codes and guidelines are strict and detailed. These codes and guidelines include provisions specifying that advertising for alcoholic drinks should not be aimed at minors or show minors consuming alcoholic beverages and should not be placed in media or sponsor events where a significant percentage of the audience is underage. The national advertising self-regulatory codes of practice⁵ that apply in the UK also ensure that advertising does not draw a relationship between alcohol and increased personal success, confidence or attractiveness.

Self-regulatory bodies review complaints from consumers and competitors and conduct monitoring exercises on their own initiatives. The UK's Advertising Standards Authority (ASA), the national advertising self-regulator, monitors the exposure of children to TV ads for alcohol. Its latest report reveals a further decline in children's exposure to all TV ads in the UK, which is likely driven by a decrease in TV viewing amongst children. However, it also suggests that children's exposure to TV ads for alcohol in the UK is falling at a faster rate than their exposure to all TV ads. Between 2008 and 2019 children's exposure to TV alcohol ads in the UK decreased by two thirds, from an average of 2.8 to an average of 0.9 ads per week⁷.

The advertising industry has also gone one step further by developing additional guidelines, principles, sector specific codes and initiatives such as the [Digital Guiding Principles](#) developed by the International Alliance for Responsible Drinking (IARD), and the [Responsible Marketing Pact](#) of the World Federation of Advertisers (WFA) to ensure transparency and responsibility in the marketing of alcoholic beverages. In another example of a company taking further action to safeguard consumers, YouTube, working closely with IARD, has just launched a new feature in the US providing the option for signed-in individuals to see fewer alcohol and gambling ads.

Advertising plays an essential role in society and in driving economic growth. It supports 5.8 million jobs across the EU⁸ and many industries such as media, arts, sport and culture depend on it for their revenues. Funding of the European media, which depend on advertising for 81%⁹ of their digital revenues, has already been significantly weakened through changing market conditions as well as the coronavirus pandemic. Further reductions in advertising expenditure would jeopardise the sustainability and plurality of European press and broadcast media which are an essential aspect of functioning democracy, necessary for scrutiny and vital for reporting and communicating information to the public.

Advertising Information Group
11 December 2020

³ Recital 29 of the [Directive \(EU\) 2018/1808 concerning the provision of audiovisual media services \(Audiovisual Media Services Directive\)](#) states: 'Similarly, Member States should be encouraged to ensure that self- and co-regulatory codes of conduct are used to effectively reduce the exposure of children and minors to audiovisual commercial communications for alcoholic beverages. Certain self- or co-regulatory systems exist at Union and national level in order to market alcoholic beverages responsibly, including in audiovisual commercial communications. Those systems should be further encouraged, in particular those aiming at ensuring that responsible drinking messages accompany audiovisual commercial communications for alcoholic beverages.'

⁴ [European Union's Better Regulation Package](#), European Commission, 2015

⁵ https://www.asa.org.uk/type/non_broadcast/code_section/18.html

⁶ https://www.asa.org.uk/type/broadcast/code_section/19.html

⁷ [Children's exposure to age-restricted TV ads](#), ASA (2019)

⁸ <https://valueofadvertising.org/>

⁹ [The Economic Contribution of Digital Advertising in Europe](#), IHS Markit, 2017

AlcoHELP

Country/Location: United Kingdom of Great Britain and Northern Ireland

URL: alcohelp.com

Submission

Our Charity, AlcoHELP, works extensively in the UK and Africa to help reduce the harms of alcohol consumption.

Attachment(s): 1

00284_55_who-gas-submission.pdf

AlcoHELP
Orchard Leigh
Ridgewell
Essex
CO9 4SG
UK

10th December 2020

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organisation (WHO)
Avenue Appia 20 1211 Geneva

Dear Director-General,

Submission on the Working Document for the development of an Action Plan to strengthen implementation of the WHO Global Alcohol Strategy (Working Document)

We have reviewed the Working Document for the development of an action plan to strengthen implementation of the WHO Global Alcohol Strategy (WHO GAS) and have the following comments and suggestions for your consideration.

AlcoHELP seeks to inform, advise, and assist, by educational means, children and adults on the consequences associated with the harmful use of alcohol.

Target 3.5 of the United Nations Sustainable Development Goals 2030 includes the objective of strengthening the prevention and treatment of substance abuse, including the harmful use of alcohol. The vision behind the *2010 Global Strategy to Reduce the Harmful Use of Alcohol* is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to alcohol and the ensuing social consequences.

AlcoHELP works with children aged 10 to 18 by direct face to face contact in school settings. This occurs in Essex. UK. Our charity trustees and other volunteers also work extensively among recovering alcoholics. In addition, we are funding the building of a school in Malawi, Africa. We recognise that education for the globally underprivileged leads to learners making positive choices.

An effective Action Plan is needed to strengthen the Global Strategy

The implementation of the Global Strategy has been uneven across the WHO regions. Between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita. Implementation of the alcohol policy best buy solutions has been insufficient in most countries around world over the last ten years. The alcohol industry has continued to interfere in alcohol policy-making processes. Therefore, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, alcohol caused three million deaths worldwide. Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally binding regulatory instruments. Without a clear Action Plan, the Global Strategy will remain

unrealized and the health, social, economic and development harms of alcohol consumption will remain high and continue to be an obstacle to achieving the Sustainable Development Goals.

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan.

Strengths of the Action Plan include:

- The focus on the '*Implementation of High-Impact Strategies and Interventions*' or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.
- The inclusion of an objective focussing on prevention and treatment capacity being an integral part of universal health coverage.

There are also areas where the Action Plan can be strengthened, including:

- Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization
- Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm
- Dealing with the alcohol industry in a single paragraph due to their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does.
- Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.

Thank you for your consideration.

Yours sincerely,

Terry Martin
Chair of Trustees
AlcoHELP
Reg UK Charity No: 1104811

Alcohol Action Ireland

Country/Location: Ireland

URL: www.alcoholireland.ie

Submission

Submission to the World Health Organization (WHO) web based consultation on the

Working Document for the development of an action plan to strengthen implementation of the Global Strategy to reduce the harmful use of alcohol.

Alcohol Action Ireland (AAI) is the independent advocate for reducing alcohol harm.

We campaign for the burden of alcohol harm to be lifted from the individual, community and State, and have a strong track record in effective advocacy, campaigning and policy research.

Our work involves providing information on alcohol-related issues, creating an understanding of alcohol-related harm and offering public policy solutions with the potential to reduce that harm, with an emphasis on the implementation of the Public Health (Alcohol) Act.

AAI support the work of the Health Services Executive - HSE Alcohol Programme, informing strategic alcohol initiatives as an instrument of public health planning. We act as the secretariat to the Alcohol Health Alliance Ireland, as its co-founder, and serve on the Board of Eurocare – European Alcohol Policy Alliance, Brussels.

Alcohol Action Ireland believes that a range of policy measures, informed by the WHO 'Best Buys' can be adopted, and contribute to the objectives of public health alcohol policy, reducing alcohol consumption in Ireland and so lessening alcohol related harms across Irish society.

We are pleased to have an opportunity to comment on the working document circulated and applaud the commitment and purpose of the WHO (the 'Organization') in engaging with such an open and transparent process.

Summary observations on the Working Document

Alcohol Action Ireland welcome the comprehensive endeavour which the working document envisages and believe it to be a solid starting point for the development of an action plan; we note with some disappointment the uneven implementation globally and the lack of tangible progress amongst the high level of objectives for the global strategy to reduce the harmful use of alcohol. In particular, we are reminded of the enormous impact on the lives of those who live with alcohol use disorders and especially those drawn into dependency.

The harm from alcohol use is indeed not just limited to health consequences and we believe the significant loss of human creativity, enterprise and potential must too be voiced.

We recognize the series of challenges in implementation of the global strategy and propose that a bolder, paradigm shift on the perception of both the use and risk of alcohol; the need for a global

normative law on alcohol, and that the maligning influence of the global alcohol economic operators be clearly identified.

The document outlines existing and emerging opportunities for reducing the harmful use of alcohol, which we recognize, with some additions on the pursuit of better lifestyles, the positive influence of social media and the dividend return from intervention.

The scope of the action plan, the goal of the action plan and the proposed operational objectives, guiding principles and key areas for global action are broadly fit for purpose but will benefit from a bolder choice of action and clarity of concept, reflective of our earlier observations to the series of challenges to meaningful progress.

Overarching missed opportunities

An ambiguity that lies within the premise to reduce the harmful use of alcohol.

Alcohol Action Ireland recognize the legal standing of alcohol throughout our society, and the freedom of enterprise to market and trade in its products. However, we are equally clear in our belief, that the inherent risk to human health, and the impact to the lives of others, from alcohol use cannot be defined, and determined to give priority to protect public health, within harmful use of alcohol alone.

Notwithstanding the political challenge to construct an unanimity to establish a Framework Convention on Alcohol Control, the inherent risk to public health must be unequivocally declared, and not qualified by degree of consumption, that alcohol use causes death, dependency, disease and disability. The absence of such clarity, and the persistent qualification of use, only facilitates further political ambivalence and fosters opportunity for economic operators to contaminate the processes to promote measures of alcohol control.

Furthermore, in providing such clarity, and public health leadership, the Organization should also champion a fundamental principle of the Right to Know; a human rights in health principle that recognizes that citizens are autonomous, independent agents with the right to make informed decisions regarding their health and well-being. It is a truism that one cannot reasonably exercise a responsibility to be informed unless fixed with sufficient knowledge to make informed choices - to be effectively informed of the inherent risk from alcohol use one must be in possession of all information to make informed choices and decisions. The absence of such a commitment is evident in the inertia of Member States to implement 'best buys' and the persist denial of risk by the economic operators.

The dichotomy of relevant stakeholders

Alcohol Action Ireland recognize the necessity for an action plan to embrace the widest possible set of stakeholders, and that collectively with unity of purpose, incremental change can be forged and realized. In this context, it is understood that the Organization would seek to align the interests of stakeholders from Member agencies, states, international partners and non-state actors. However, a fundamental dilemma arises when a false equivalence is established amongst these various stakeholders.

A principle of equivalence that puts the role and purpose of civil society organizations, professional associations and research institutions - seeking only to protect public health - as equal contributors to an action plan, as that of the economic operators, who hold a principal responsibility for the risk to public health, is flawed.

Civil society organizations.

Alcohol Action Ireland would forward a view that the voice of civil society organizations, professional associations and academia are both the primary agitator and sustainer of strategic progress on reducing the use of alcohol and related harm. This primary contribution must be recognized by the Organization, not just as an unique constituent but as a stakeholder who needs special attention, assistance and support. It is they, and they alone, who largely uphold the universal principles of public health interventions and who, in recognizing the duplicitous commercial practice of economic operators, would not wish to coalesce in an endeavor that affords them an equality of integrity or purpose.

While civil society organizations, motivated by the human tragedies that alcohol use designs, will always be at the vanguard of activism, its contribution to any action plan, and its authority, founded on a deep experience and knowledge of the inherent risk and lasting damage of alcohol use, must be acknowledged with greater purpose.

Economic operators.

At the heart of the Working document for the development of an Action Plan is an accommodation of the economic operators – the global alcohol industry and trade. This accommodation seeks to afford the pecuniary interests of alcohol producers and trade a valid contribution to a global strategic endeavour to reduce the harmful use of alcohol. It is our view, that this accommodation is irrational and cannot be sustainable, as the principle purpose of the economic operator is to advance and expand the global alcohol market.

Equally, while the ambition of the alcohol industry's corporate and social responsibility programmes contrives evidence of its contribution as a solutions-based partner to a growing public health crisis it perpetuates, their relentless commercial practices and rationale ensures the inherent risk of alcohol use is denied, the untold harm to others is undermined, while remaining free of the societal cost it has caused.

Meaningful progress to strengthen implementation of the global strategy to reduce the harmful use of alcohol, its goal and objectives, will need the contribution of the economic operators to be re-evaluated.

Specific commentary on the development of an action plan and the proposed text.

Setting the scene (p.1)

While we concur with much of the direction outlined, we query the on-going contribution of the SAFER initiative going forward, and ask, does this initiative not add a layer of confusion to the wider alcohol policy strategic direction? While developed in good faith to support and reinforce the Sustainable Development Goals, it may be appropriate to utilize this on-going development of an action plan, to streamline the strategic alcohol policy objectives within one unified purpose.

We would suggest that the lack of tangible progress on reducing global alcohol consumption per capita, is indicative of the relentless commercial pursuit of the drinker; the decline of drinkers across the regions may be testimony to a modest appreciation of the inherent risk of alcohol use.

In outlining that the harmful use of alcohol is not limited to health consequences, we suggest the Organization could also address the potential loss of creativity, enterprise and human endeavor attributable to alcohol use, and that, in acknowledging insufficient reductions in alcohol related morbidity and mortality, one testifies to a persistent, fundamental lack of societal understanding of the risk.

Challenges in implementation of the Global Strategy (p.3)

The document speaks to many challenges to the development and implementation of effective alcohol policies – central to this complexity is the accommodation of economic interests; were the policies pursued singularly on the basis of public health objectives and the economic interests or priorities relegated, development and implementation would be inordinately easier.

Many challenges outlined such as prevailing social norms, commercial messaging, the lack of strong international leadership, competing interests and the lack of binding regulatory instruments, all persist because of the political primacy afforded the economic operators.

Opportunities for reducing the harmful use of alcohol (p.5)

The document speaks to a decrease among young people with a view that this ‘seems to be continuing into the next age group’ – our national experience would suggest that an ageing maturity shift is critical here and that while early adolescents use of alcohol has declined, the frequent use amongst young adults has been consolidated and shows no indication of slowing.

We believe the document articulates a crucial point on the Return on Investment from alcohol control’s ‘Best buys’ and we encourage bolder leadership from the Organization in this regard as it brings an financial immediacy that is attractive to individual government action.

Scope of the Action Plan (p.6)

As previously outlined, the centrality of a contribution from economic operators, fundamentally weakens the scope of the plan; the transnational reach and accompanying financial resources of the global alcohol producers enables the commercial interest to undermine concerted actions.

Separately, and with reference to linking this action plan to other relevant global action plans, Alcohol Action Ireland, mindful of the growing prevalence of fetal alcohol spectrum disorders (FASDs), propose that the Organization’s ‘Every Newborn’ action plan be linked.

Goal of the Action (p.7)

While the goal of the action plan is clear, Alcohol Action Ireland believes it should seek to further reinforce the inherent risk of alcohol use and the role that greater understanding can achieve. Also, while the goal recognizes the interaction at regional levels, we would recommend that regional entities

and other supranational organizations such as the European Union, the Organization for Economic Co-operation and Development, et al., be engaged around the goals and objectives of the action plan.

Operational objectives/principles of the action plan (p.9)

Alcohol Action Ireland agree with the objectives/principles as stated but believe that the fourth operational objective could be strengthened to hold a higher ambition on ensuring greater understanding and appreciation of the risk and harm associated with alcohol. Equally, the objectives could recognize the citizens' right to know the inherent risk of alcohol use.

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Alcohol Action Ireland are broadly supportive of the proposed action areas, global targets and actions outlined. However, we restate our view that the equivalence afforded the economic operators will ensure that the ambition articulated will be slowed and hindered. The evidence for such an assertion is evident in the uneven implementation globally and the lack of tangible progress amongst the high level of objectives for the global strategy to reduce the harmful use of alcohol.

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Proposed actions for Member States, No.6 – national alcohol awareness day; an international day of awareness would be more helpful.

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Proposed actions for International partners and non-State actors, No.2 – invitation to scale up their activities in support of awareness and advocacy campaigns; this remains a matter of financial and human resources. The action area should lead the advocacy for a national financial instrument such as a levy on alcohol sales, to resource such activities. This type of universal levy/global tax could also support the principal aims of Action Area 5: knowledge production and information systems, and Action area 6: resource mobilization.

Alcohol Action Ireland wish the Organization well in its endeavor to develop an action plan to strengthen implementation of the global strategy to reduce the harmful use of alcohol. We hope our contribution can be of some assistance and we remain available to your good office should any further clarification be required.

Alcohol Action Ireland

December 2020.

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00477_09_who-working-paper-aai-submission-2020.pdf

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**Alcohol Action Ireland
December 2020.**

Alcohol Action NZ

Country/Location: New Zealand

URL: alcoholaction.co.nz

Submission

Submission of Alcohol Action NZ Inc. to

WHO consultation on the Working Document for Development of an Action Plan to strengthen implementation of the Global Strategy to Reduce Harmful Use of Alcohol

Alcohol Action NZ (AANZ) is a NGO based in Aotearoa/New Zealand established by medical professionals in 2009 to advocate for evidence-based policy to reduce harm from alcohol.

AANZ has read the working document for development of an action plan to strengthen implementation of the Global Strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration.

We consider that the most important overarching aspects of any action plan are:

1. an equity focus
2. strong emphasis on implementing high impact actions (“best buys”)
3. exclusion of commercial alcohol actors from policy discussion and development of recommendations
4. commitment to the development of an international treaty, analogous to the Framework Convention on Tobacco Control.

Further specific comments:

5. Part of the context of this plan includes the current projections of increases in consumption and harm globally, the strategies of trans-national alcohol corporations (including targeting of LMIC), and the vast expansion of digital marketing. We support the inclusion of these important influences on planning, in “Setting the Scene”.
6. AANZ urges the WHO to honour its commitment to improving indigenous health, by including actions and indicators that explicitly address equity. In Aotearoa/New Zealand, harms from alcohol affect Māori (indigenous) people more than others, as in similar colonised countries. AANZ would also like to see the Working Document recognise the many cultures (defined by ethnicity, religion, age or peer group) who have not normalised use of alcohol.
7. AANZ supports a very strong and explicit support of the use of the five high-impact evidence-based interventions as described in the SAFER guidance. This includes using measures related to implementation of these policies in monitoring of progress.
8. AANZ is concerned that the working document refers to alcohol industry entities as ‘economic actors’ and includes them as legitimate stakeholders. They have an explicit conflict of interest and long substantiated history of opposing effective alcohol policies and promoting misinformation about alcohol

and health. AANZ support the exclusion of parties with conflicts of interest from any role in the development of the Action Plan.

9. AANZ supports the development of a legally binding international treaty to reduce the influence of commercial interests in policy making and practice. As the working document states “Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant global impact on population health that is not controlled at the international level by legally-binding regulatory frameworks”

10. A strong global action plan and a binding treaty are urgently need to support member states to prioritise action on alcohol and withstand pressure from industry.

Alcohol Action NZ thanks WHO for the opportunity to submit to this consultation.

Attachment(s): 1

00375_37_submission-of-alcohol-action-nz-inc-to-who-action-plan.pdf

Submission of Alcohol Action NZ Inc. to

WHO consultation on the **Working Document for Development of an Action Plan to strengthen implementation of the Global Strategy to Reduce Harmful Use of Alcohol**

Alcohol Action NZ (AANZ) is a NGO based in Aotearoa/New Zealand established by medical professionals in 2009 to advocate for evidence-based policy to reduce harm from alcohol.

AANZ has read the working document for development of an action plan to strengthen implementation of the Global Strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration.

We consider that the most important overarching aspects of any action plan are:

1. an equity focus
2. strong emphasis on implementing high impact actions (“best buys”)
3. exclusion of commercial alcohol actors from policy discussion and development of recommendations
4. commitment to the development of an international treaty, analogous to the Framework Convention on Tobacco Control.

Further specific comments:

5. Part of the context of this plan includes the current projections of increases in consumption and harm globally, the strategies of trans-national alcohol corporations (including targeting of LMIC), and the vast expansion of digital marketing. We support the inclusion of these important influences on planning, in “Setting the Scene”.
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10. A strong global action plan and a binding treaty are urgently need to support member states to prioritise action on alcohol and withstand pressure from industry.

Alcohol Action NZ thanks WHO for the opportunity to submit to this consultation.

Alcohol and Drug Foundation

Country/Location: Australia

URL: adf.org.au

Submission

For our organisation, a strong Action Plan will be one that includes a focus on 'best buys' alcohol policies while emphasising the importance of prevention initiatives that seek to reduce risk factors and increase protective factors for alcohol use and harm. The ADF commends the inclusion of an objective focussing on prevention and treatment capacity and suggests that the critical role of prevention be further emphasised with the inclusion of a specifically prevention-focused action for Member States under Action Area 6 (please see below).

We offer further specific suggestion as to language amendments, and general suggestions for opportunities to strengthen the Working Document overall.

Attachment(s): 1

00302_66_adf-who-wrkdsub-2020.pdf

11 December 2020

Alcohol and Drug Foundation
adf@adf.org.au

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organisation (WHO)
Avenue Appia 20 1211 Geneva

Dear Director-General,

Following review of the Working Document for the development of an Action Plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol, the Alcohol and Drug Foundation provides the following suggestions for your consideration.

About the Alcohol and Drug Foundation

Founded in 1959, the Alcohol and Drug Foundation (ADF) has contributed 60 years of service to communities across Australia. The ADF works in partnerships with communities to reduce the burden of disease caused by alcohol and other drug problems. The ADF's focus is on prevention and early intervention. Our strategies include community action, health promotion, education, information, policy, advocacy and research.

The ADF mission is to 'Inspire positive change and deliver evidence-based approaches to minimise alcohol and drug harm.' For our organisation, a strong Action Plan will be one that includes a focus on 'best buys' alcohol policies while emphasising the importance of prevention initiatives that seek to reduce risk factors and increase protective factors for alcohol use and harm.

Thank you for your consideration.
Yours sincerely,

Dr. Erin Lalor
CEO
Alcohol and Drug Foundation

Level 12
607 Bourke Street
Melbourne VIC 3000

PO Box 818
North Melbourne
VIC 3051

03 9611 6100
adf@adf.org.au
adf.org.au ABN 66 057 731 192

Submission on the Working Document for the development of an Action Plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol (Working Document)

The ADF commends the inclusion of an objective focussing on prevention and treatment capacity and suggests that the critical role of prevention be further emphasised with the inclusion of a specifically prevention-focused action for Member States under Action Area 6 (please see below).

The case for investment in alcohol preventative health is compelling. The longer alcohol use is delayed, the better the long-term outcomes for individuals and their community. Pressure is reduced on alcohol and mental health treatment sectors, hospitals, education, and the criminal justice system as more people are able fulfil their social and economic potential with their lives unlimited by alcohol harm. A stronger emphasis on prevention, and specifically a focus on increasing protective factors in communities, would greatly strengthen the preventative approach of the Action Plan.

Additionally, the Working Document's inclusion of global targets and indicators, the recognition of the need to increase resources, and the focus on SAFER strategies are strong starting points for the development of the Action Plan.

Specific recommendations

In ACTION AREA 1: IMPLEMENTATION OF HIGH-IMPACT STRATEGIES AND INTERVENTIONS.

SAFER be amended to read as:

- Strengthen restrictions on alcohol availability
- Advance and enforce drink-driving countermeasures
- Facilitate access to screening, *primary prevention programs*, brief interventions and treatment
- Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion.
- Raise prices on alcohol through excise taxes and other pricing policies.

Include a **new target 1.4** under Global targets for Action area 1, to read as:

Global target 1.1: By 2030, 75% of countries have introduced and/or strengthened and sustainably enforced implementation of high-impact policy options and interventions.

Global target 1.2: At least a x% relative reduction in alcohol per capita (among those aged 15 years and older) consumption by 2025 and a x% relative reduction by 2030.

Global target 1.3: By 2030, 80% of the world's population are protected from the harmful use of alcohol by sustained implementation and enforcement of high-impact policy options with due consideration of national contexts, priorities and available resources.

Global target 1.4: *A reduction in harmful alcohol consumption by 10% by 2025, per the WHO Global Action Plan for the Prevention of and Control of Non-Communicable Diseases 2013–2020.*

The ADF suggest the Proposed actions for the **WHO Secretariat: Action 4** be amended to read as:

Maintain dialogues with representatives of economic operators in the area of alcoholic beverage production and trade on how they can best contribute to the reduction of alcohol-related harm within their core roles. *The basis of this should be that the alcohol industry be precluded from involvement in health policy making. This will ensure alignment with Action 2.*

In ACTION AREA 6: RESOURCE MOBILIZATION the ADF recommends the **addition of a Member States: Action 7** that specifically focuses on prevention.

While there is no single factor that will guarantee a person does, or does not, experience harms from alcohol, initiatives that strengthen and support personal and social protective factors reduce the likelihood that people, particularly young people, will engage in problematic alcohol use. This reduction can promote mental and physical health across the life course and reduce the overall risk of experiencing harms from alcohol.

General recommendations

There are also areas where the Action Plan can be strengthened, including:

- Reducing and restructuring the number of prioritised actions and having a greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm.
- Clarifying the role of actors, particularly limiting the discussion of corporations and lobby groups that have a conflict of interest in financially benefitting from the sale of alcohol, and who have no role in policy development.
- Having a greater focus on governance, resourcing, review, and implementation.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.

Alcohol and Drug Information Centre

Country/Location: Sri Lanka

URL: <https://adicsrilanka.org/>

Submission

Submission from the Alcohol and Drug Information Centre (ADIC) – Sri Lanka

WHO Web based consultation 16 November – 13 December 2020

Working Document to develop an action plan for improving WHO global alcohol strategy implementation

We are grateful for the opportunity to comment on the working document and appreciate the effort by WHO in conducting an ambitious consultative process. We have reviewed the document and have the following comments and suggestions for your consideration.

Alcohol & Drug Information Centre (ADIC) – Sri Lanka was inaugurated in April 1987 and was established as an independent organization in 1990. ADIC is registered under the Companies Act No. 7 of 2007 and Voluntary Social Services Act No. 31 of 1980 as amended by Act No. 8 of 1998 of Sri Lanka and obtained Approved Charity Status in 1992. Over the last 30 years ADIC Sri Lanka has developed to be a well-recognized resource centre, promoting demand reduction of alcohol, tobacco and other drugs (ATOD) and advocating effective policy formulation for ATOD control nationally, regionally and internationally.

In our submission we will first outline a few key points, what we support, then we go on to give more detailed comments and proposals on the different parts of the working document.

Thank you for your consideration.

*WHO GAS = Global Alcohol Strategy

Key comments

1. We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.
2. We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.
3. We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with

other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol issues. We further propose to remove two other points in the list of challenges (see detailed description below).

4. The absence of a global, legally binding instrument, leading – among other things – to a lack of protection from alcohol industry interference, is the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).

5. Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.

What we support

The Working Document provides a sound starting point for the development of an action plan. Strengths of the action plan include:

1. The focus on the ‘Implementation of High-Impact Strategies and Interventions’ or SAFER strategies,
2. The strengthening of the mandate and case for global and Member States’ action,
3. The inclusion of global targets and indicators,
4. The emphasis on alcohol policy mainstreaming and cross-sectorial work to tackle alcohol harms,
5. The acknowledgement of the need to increase resources and to explore innovative ways for resource mobilization required for action,
6. The inclusion of an objective focussing on prevention and treatment capacity being an integral part of universal health coverage,
7. The inclusion of “new” ideas for global actions, such as:
 - a. Awareness day/ week,
 - b. Revising the nomenclature,
 - c. Linking the alcohol burden more clearly to the health system, and
 - d. Technical capacity-building.

Detailed comments on the working document

In general, we welcome and support large parts of the working document as elements of the future action plan.

Regarding Setting the scene

We support the focus on strengthening global action, building on the mandate that Member States have given WHO in 2010 and that Member States have renewed with the WHO governing body decisions in 2019 and 2020.

Concretely, we welcome and support the effort to define clear targets and indicators.

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan. We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan (see below).

We welcome and support the analysis of and emphasis on the potential of mainstreaming alcohol policy into other relevant policy sectors and to promote cross-sectorial work to advance alcohol policy development.

Fourthly, we welcome and support the emphasis on alcohol's role across the GPW13's triple billion target. This shows what the potential of this new alcohol action plan could be: to strengthen the mandate and case for global action on the entirety of alcohol harm – in this way unlocking the full potential of alcohol policy solutions.

Proposing a bold overarching target

While we welcome and support the global action area targets and the indicators listed in Annex I, we miss one overarching target that underpins the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries.

Placing SAFER front and center

The setting the scene section can be improved by placing the SAFER alcohol policy blueprint front and center. The case for action and the return on investment should be made clear from the outset: Implementation of the three best buys would result in a return on investment of \$9 for every \$1 invested. Already in 2010, the WHO Global Health Report outlined that:

“Raising taxes on alcohol to 40% of the retail price could have an even bigger impact [than a 50% increase in tobacco taxation]. Estimates for 12 low-income countries show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries “

This locates the alcohol action immediately within wider efforts to achieve universal health coverage and to reach the SDGs.

Regarding the WHO GAS implementation

We support the analysis of the last ten years of WHO GAS implementation around the world.

While we do not disagree with the presentation of the evidence, we ask for stronger conclusions and clearer messages regarding the evaluation of the decade of WHO GAS implementation in this section.

WHO GAS implementation over the last ten years has been ineffective, inadequate and outdated. Some of the evidence should be presented to set the scene for the action plan.

- Alcohol availability regulation remains inadequate, according to findings from the WHO Global Alcohol Status 2018, to compound the situation, alcohol is actually becoming more widely and easily available. The number of licenses to produce, distribute and sell alcohol – a marker for increased rather than decreased availability – is increasing in much of the world, particularly in lower-income countries.
- Levels of treatment coverage vary substantially across countries but are inadequate across the world. Only 14% of reporting countries indicated high treatment coverage, and 28% of reporting countries indicated very limited or close to zero treatment coverage.
- Alcohol marketing regulations remain inadequate, too. Digital alcohol marketing restrictions are far behind technological innovation in the alcohol industry. 28% of countries had no regulations on any media type in 2016, most of them being located in the African or Americas regions.
- While 95% of all reporting countries implement alcohol excise taxes, fewer than half use the other price strategies highlighted in the WHO GAS – such as adjusting taxes to keep up with inflation and income levels, imposing minimum pricing policies, or banning below-cost selling or volume discounts. This shows that alcohol pricing policies remain inadequate. For example, in 2017 only 59% of responding countries had implemented a tax increase on alcoholic beverages since the adoption of the WHO GAS. Only a third of countries adjust those taxes regularly for inflation, and eight countries (five of them in the WHO European Region) reported increasing their subsidies for alcohol production.

It is important that this analysis is added to the chapter about WHO GAS implementation. It is an understatement to conclude that implementation has been “uneven”. The evidence shows that the majority of countries falls short of adequately responding to the alcohol burden with the most cost-effective and impactful alcohol policy solutions.

Protecting children, youth and adults who don't use alcohol

We welcome and support the discussion of the alcohol abstaining population in the world. Protecting children, youth and adults from pressures to start consuming alcohol and in their non-consuming behaviour is a guiding principle of the WHO GAS.

Regarding WHO GAS implementation challenges

We welcome and support the analysis of the challenges that WHO GAS implementation was faced with over the last decade. We note that WHO examines 15 challenges.

The reason why this section is so important is that it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective, inadequate and outdated.

We propose to remove three items from the description of the challenges for WHO GAS implementation: Number one, two and three.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol (health) issues.

Secondly, while there might be differences between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention are equally able to take political action to reduce their alcohol burden.

Thirdly, we understand that intersectoral approaches to societal problems are not easy, but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

A more systematic order of implementation challenges

Not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

Protection against alcohol industry interference

Alcohol remains the only psychoactive substance that is not under any binding international control regime, despite its massive global burden. Therefore, protections against alcohol industry interference are missing and pose the biggest challenge to WHO GAS implementation.

The alcohol industry deploys its political, market and purchase power to interfere in public health policymaking in order to delay, derail and destroy alcohol policy-making efforts. They also leverage aggressive marketing spending, for example in the digital world – as the coronavirus crisis has brought into sharp focus, and they deploy corporate social responsibility schemes to white-wash their image, cultivate relationships and avoid statutory public health policies.

We urge for such a description to be added to the next document. Ten years of evidence from attempts to implement the WHO GAS have contributed compelling evidence.

Regarding WHO GAS implementation opportunities

We welcome and support the analysis of the opportunities for preventing and reducing alcohol harm; but the section should be better framed as opportunities to accelerate action on WHO GAS implementation (as are the challenges) – as called for by Member States.

We agree with all the opportunities outlined in the working document. The reason why this section is so important is that it provides context for global and national action to capitalize on these opportunities.

Regarding Scope of the action plan

We welcome and support the scope of the action plan to comprise concrete action and significant improvements to the global governance of alcohol policy development. Importantly, we welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

We support and welcome the actions suggested for Member States and the WHO. Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. But we support the ambition, quantity and quality of the actions outlined because it signifies Member States' obligation to ensure their citizens are protected from alcohol harm. The proposed actions also illustrate that it is WHO's responsibility to live up to the strong mandate it has received in 2010 and on different occasions since then.

All stakeholders are not equal

In this context, we must highlight that all stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm. There is a fundamental conflict of interest on part of the alcohol industry.

Clearly, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world (see above). Therefore, we make concrete suggestions for how the role of different stakeholders can be better reflected in the action plan.

Regarding Goal of the action plan

We welcome and support the reiteration of the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We suggest including the health, social, economic and sustainable development consequences of alcohol but we fully endorse this overarching goal.

What we want to improve

There needs to be a section/ chapter dealing with the vision, mission and targets of the action plan. Goals and implementation could be kept separate for purpose of clarity.

Commenting on the formulation of the goal: Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences of alcohol in the description of the goal.

Regarding Proposed operational objectives

We welcome and strongly support the action-oriented nature of the working document’s outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions.

In support of the operational objectives, we propose a logical model, and we propose adding two more operational objectives that have gone missing from the WHO GAS’ objectives.

What we want to add

We propose to add two more operational objectives. Our analysis of the working document and the WHO GAS has shown that some elements of the original objectives went missing. While we support the operational objectives as suggested in the working document, we are convinced that the following elements should also be included in the action plan’s operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Objective 8 builds on missing elements contained in WHO GAS objective 4.

Regarding proposed key areas for global action

Broadly, we welcome and support the set of 6 key areas for global action, including the quantity and quality of the actions detailed. Some elements can be improved, some elements are missing, and some elements should be reworked while some others should be removed – as outlined in Movendi International’s submission, which we endorse.

We propose to reframe and rework the key areas for global action as “framework for action”, as for example the WHO Global Action Plan for Physical Activity (GAPPA) does. This allows to streamline the actions and create greater coherence across the action areas.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO. Therefore, we propose to include civil society and international partner action in a separate section and to focus Member States and WHO action in the “Framework for action”.

Global action on reporting about alcohol consumption, related harm and policy development should reflect the magnitude and urgency of addressing the alcohol burden. In tobacco control, a global report is launched every year. For alcohol prevention and control that should be the ambition, too.

Role of the alcohol industry

We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. The working document remains incoherent, as is the WHO GAS.

It is critical that the action plan overcomes this incoherence within the frames of the mandate given by Member States through the WHO GAS but in line with a decade of evidence about the alcohol industry's role in delaying, derailing and destroying attempts to implement the WHO GAS.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Regarding improvements to the global governance and infrastructure for alcohol policy development

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitating leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. The reasons are clear and have indirectly addressed in the working document. Therefore, we are convinced that the action plan benefits from including a section about infrastructure and governance improvements – applying lessons learned from other health areas.

Examples of such infrastructure on the level of global action could be:

- A global ministerial conference on alcohol under the guidance of WHO
- A Global Fund for Alcohol Prevention
- A global initiative to advance alcohol taxation
- A functioning international network of alcohol focal points, like there is for NCDs government focal points
- A mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals
- Civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues
- A specific WHO program on alcohol to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called "Infrastructure".

Changing the way that alcohol use and harm is referred to throughout the document

As stated above, we support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

Attachment(s): 1

00358_27_adic-submission-to-who-working-document-2020.pdf



Submission from the Alcohol and Drug Information Centre (ADIC) – Sri Lanka

WHO Web based consultation 16 November – 13 December 2020

Working Document to develop an action plan for improving WHO global alcohol strategy implementation

We are grateful for the opportunity to comment on the working document and appreciate the effort by WHO in conducting an ambitious consultative process. We have reviewed the document and have the following comments and suggestions for your consideration.

Alcohol & Drug Information Centre (ADIC) – Sri Lanka was inaugurated in April 1987 and was established as an independent organization in 1990. ADIC is registered under the Companies Act No. 7 of 2007 and Voluntary Social Services Act No. 31 of 1980 as amended by Act No. 8 of 1998 of Sri Lanka and obtained Approved Charity Status in 1992. Over the last 30 years ADIC Sri Lanka has developed to be a well-recognized resource centre, promoting demand reduction of alcohol, tobacco and other drugs (ATOD) and advocating effective policy formulation for ATOD control nationally, regionally and internationally.

In our submission we will first outline a few key points, what we support, then we go on to give more detailed comments and proposals on the different parts of the working document.

Thank you for your consideration.

*WHO GAS = Global Alcohol Strategy

Key comments

1. **We strongly disagree with the role assigned to the alcohol industry** in the working document, especially in the key areas for global action. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.
2. **We propose bold, ambitious overall targets** of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.
3. **We caution against the description of alcohol harm as “complex” problem** because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol issues. We further propose to remove two other points in the list of challenges (see detailed description below).
4. **The absence of a global, legally binding instrument**, leading – among other things – to a lack of protection from alcohol industry interference, is the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).
5. **Associated to alcohol use are not “only” the health and social harms**, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.

What we support

The Working Document provides a sound starting point for the development of an action plan. Strengths of the action plan include:

1. The focus on the 'Implementation of High-Impact Strategies and Interventions' or SAFER strategies,
2. The strengthening of the mandate and case for global and Member States' action,
3. The inclusion of global targets and indicators,
4. The emphasis on alcohol policy mainstreaming and cross-sectorial work to tackle alcohol harms,
5. The acknowledgement of the need to increase resources and to explore innovative ways for resource mobilization required for action,
6. The inclusion of an objective focussing on prevention and treatment capacity being an integral part of universal health coverage,
7. The inclusion of "new" ideas for global actions, such as:
 - a. Awareness day/ week,
 - b. Revising the nomenclature,
 - c. Linking the alcohol burden more clearly to the health system, and
 - d. Technical capacity-building.

Detailed comments on the working document

In general, we welcome and support large parts of the working document as elements of the future action plan.

Regarding Setting the scene

We support the focus on strengthening global action, building on the mandate that Member States have given WHO in 2010 and that Member States have renewed with the WHO governing body decisions in 2019 and 2020.

Concretely, we welcome and support the effort to define clear targets and indicators.

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan. We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan (see below).

We welcome and support the analysis of and emphasis on the potential of mainstreaming alcohol policy into other relevant policy sectors and to promote cross-sectorial work to advance alcohol policy development.

Fourthly, we welcome and support the emphasis on alcohol's role across the GPW13's triple billion target. This shows what the potential of this new alcohol action plan could be: to strengthen the mandate and case for global action on the entirety of alcohol harm – in this way unlocking the full potential of alcohol policy solutions.

Proposing a bold overarching target

While we welcome and support the global action area targets and the indicators listed in Annex I, we miss one overarching target that underpins the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries.

Placing SAFER front and center

The setting the scene section can be improved by placing the SAFER alcohol policy blueprint front and center. The case for action and the return on investment should be made clear from the outset: Implementation of the three best buys would result in a return on investment of \$9 for every \$1 invested. Already in 2010, the WHO Global Health Report outlined that:

“Raising taxes on alcohol to 40% of the retail price could have an even bigger impact [than a 50% increase in tobacco taxation]. Estimates for 12 low-income countries show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries “

This locates the alcohol action immediately within wider efforts to achieve universal health coverage and to reach the SDGs.

Regarding the WHO GAS implementation

We support the analysis of the last ten years of WHO GAS implementation around the world.

While we do not disagree with the presentation of the evidence, **we ask for stronger conclusions and clearer messages regarding the evaluation of the decade of WHO GAS implementation in this section.**

WHO GAS implementation over the last ten years has been ineffective, inadequate and outdated. **Some of the evidence should be presented to set the scene for the action plan.**

- Alcohol availability regulation remains inadequate, according to findings from the WHO Global Alcohol Status 2018, to compound the situation, alcohol is actually becoming more widely and easily available. The number of licenses to produce, distribute and sell alcohol – a marker for increased rather than decreased availability – is increasing in much of the world, particularly in lower-income countries.
- Levels of treatment coverage vary substantially across countries but are inadequate across the world. Only 14% of reporting countries indicated high treatment coverage, and 28% of reporting countries indicated very limited or close to zero treatment coverage.
- Alcohol marketing regulations remain inadequate, too. Digital alcohol marketing restrictions are far behind technological innovation in the alcohol industry. 28% of countries had no regulations on any media type in 2016, most of them being located in the African or Americas regions.
- While 95% of all reporting countries implement alcohol excise taxes, fewer than half use the other price strategies highlighted in the WHO GAS – such as adjusting taxes to keep up with inflation and income levels, imposing minimum pricing policies, or banning below-cost selling or volume discounts. This shows that alcohol pricing policies remain inadequate. For example, in 2017 only 59% of responding countries had implemented a tax increase on alcoholic beverages since the adoption of the WHO GAS. Only a third of countries adjust those taxes regularly for inflation, and eight countries (five of them in the WHO European Region) reported increasing their subsidies for alcohol production.

It is important that this analysis is added to the chapter about WHO GAS implementation. It is an understatement to conclude that implementation has been “uneven”. The evidence shows that the majority of countries falls short of adequately responding to the alcohol burden with the most cost-effective and impactful alcohol policy solutions.

Protecting children, youth and adults who don't use alcohol

We welcome and support the discussion of the alcohol abstaining population in the world. Protecting children, youth and adults from pressures to start consuming alcohol and in their non-consuming behaviour is a guiding principle of the WHO GAS.

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We welcome and support the analysis of the challenges that WHO GAS implementation was faced with over the last decade. We note that WHO examines 15 challenges.

The reason why this section is so important is that it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective, inadequate and outdated.

We propose to remove three items from the description of the challenges for WHO GAS implementation: Number one, two and three.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol (health) issues.

Secondly, while there might be differences between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention are equally able to take political action to reduce their alcohol burden.

Thirdly, we understand that intersectoral approaches to societal problems are not easy, but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

A more systematic order of implementation challenges

Not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

Protection against alcohol industry interference

Alcohol remains the only psychoactive substance that is not under any binding international control regime, despite its massive global burden. Therefore, protections against alcohol industry interference are missing and pose the biggest challenge to WHO GAS implementation.

The alcohol industry deploys its political, market and purchase power to interfere in public health policymaking in order to delay, derail and destroy alcohol policy-making efforts. They also leverage aggressive marketing spending, for example in the digital world – as the coronavirus crisis has brought into sharp focus, and they deploy corporate social responsibility schemes to white-wash their image, cultivate relationships and avoid statutory public health policies.

We urge for such a description to be added to the next document. Ten years of evidence from attempts to implement the WHO GAS have contributed compelling evidence.

Regarding WHO GAS implementation opportunities

We welcome and support the analysis of the opportunities for preventing and reducing alcohol harm; but the section should be better framed as opportunities to accelerate action on WHO GAS implementation (as are the challenges) – as called for by Member States.

We agree with all the opportunities outlined in the working document. The reason why this section is so important is that it provides context for global and national action to capitalize on these opportunities.

Regarding Scope of the action plan

We welcome and support the scope of the action plan to comprise concrete action and significant improvements to the global governance of alcohol policy development. Importantly, we welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

We support and welcome the actions suggested for Member States and the WHO. **Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively.** But we support the ambition, quantity and quality of the actions outlined because it signifies Member States' obligation to ensure their citizens are protected from alcohol harm. The proposed actions also illustrate that it is WHO's responsibility to live up to the strong mandate it has received in 2010 and on different occasions since then.

All stakeholders are not equal

In this context, **we must highlight that all stakeholders in WHO GAS implementation are not equal.** The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm. There is a fundamental conflict of interest on part of the alcohol industry.

Clearly, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world (see above). Therefore, **we make concrete suggestions for how the role of different stakeholders can be better reflected in the action plan.**

Regarding Goal of the action plan

We welcome and support the reiteration of the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We suggest including the health, social, economic and sustainable development consequences of alcohol but we fully endorse this overarching goal.

What we want to improve

There needs to be a section/ chapter dealing with the vision, mission and targets of the action plan. Goals and implementation could be kept separate for purpose of clarity.

Commenting on the formulation of the goal: Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. **We suggest including the health, social, economic and sustainable development consequences of alcohol in the description of the goal.**

Regarding Proposed operational objectives

We welcome and strongly support the action-oriented nature of the working document’s outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions.

In support of the operational objectives, **we propose a logical model, and we propose adding two more operational objectives that have gone missing from the WHO GAS’ objectives.**

What we want to add

We propose to add two more operational objectives. Our analysis of the working document and the WHO GAS has shown that some elements of the original objectives went missing. While we support the operational objectives as suggested in the working document, we are convinced that the following elements should also be included in the action plan’s operational objectives:

- **NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and**

- **NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.**

Objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Objective 8 builds on missing elements contained in WHO GAS objective 4.

Regarding proposed key areas for global action

Broadly, we welcome and support the set of 6 key areas for global action, including the quantity and quality of the actions detailed. **Some elements can be improved, some elements are missing, and some elements should be reworked while some others should be removed** – as outlined in Movendi International’s submission, which we endorse.

We propose to reframe and rework the key areas for global action as “framework for action”, as for example the WHO Global Action Plan for Physical Activity (GAPPA) does. This allows to streamline the actions and create greater coherence across the action areas.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO. Therefore, **we propose to include civil society and international partner action in a separate section and to focus Member States and WHO action in the “Framework for action”.**

Global action on reporting about alcohol consumption, related harm and policy development should reflect the magnitude and urgency of addressing the alcohol burden. In tobacco control, a global report is launched every year. For alcohol prevention and control that should be the ambition, too.

Role of the alcohol industry

We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. The working document remains incoherent, as is the WHO GAS.

It is critical that the action plan overcomes this incoherence within the frames of the mandate given by Member States through the WHO GAS but in line with a decade of evidence about the alcohol industry’s role in delaying, derailing and destroying attempts to implement the WHO GAS.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Regarding improvements to the global governance and infrastructure for alcohol policy development

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitating leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. The reasons are clear and have indirectly addressed in the working document. Therefore, **we are convinced that the action plan benefits from including a section about infrastructure and governance improvements – applying lessons learned from other health areas.**

Examples of such infrastructure on the level of global action could be:

- A global ministerial conference on alcohol under the guidance of WHO
- A Global Fund for Alcohol Prevention
- A global initiative to advance alcohol taxation
- A functioning international network of alcohol focal points, like there is for NCDs government focal points
- A mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals
- Civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues
- A specific WHO program on alcohol to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore **we propose they be included in the section of the action plan called "Infrastructure".**

Changing the way that alcohol use and harm is referred to throughout the document

As stated above, we support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. For instance, by **moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.**

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

Alcohol Beverages Australia

Country/Location: Australia

URL: <https://www.alcoholbeveragesaustralia.org.au/>

Submission

1. Member states should have a suite of policy options available to them in the Global Strategy.

ABA notes that Australia has a national alcohol strategy which has already had extensive consultation and considered review of how governments at federal and state and territory level should design and execute appropriate policies to address alcohol-related harm. Any action plan should recognise that member states should have the flexibility to implement national strategies, and that no individual policies should be prioritised over other possible interventions. This was what was agreed by the WHA in 2010.

In particular, we note the new proposal referred to as “SAFER”, which was produced without member state involvement or endorsement. The Australian national alcohol strategy adopts individual policy proposals, and often prioritises targeted initiatives rather than population-wide approaches which are regarded as a blunt instrument. The SAFER initiative should have no higher priority than other interventions, particularly ones which member states have previously endorsed. Global targets should not refer to SAFER and should be geared towards the effectiveness of policies, not the implementation of policies.

2. The focus must remain on reducing the harmful consumption of alcohol, not on consumption per se. This is consistent with the wording of the Global Strategy and the UNPD.

Recommendations around measuring a reduction of total consumption are a blunt instrument, and not appropriate for members states which have sophisticated data where policy interventions are currently focused on harmful drinking, including but not limited to heavy episodic drinking and underage drinking. Australia has recorded positive trends around harmful consumption because its interventions have focused on harm, and this work should not be undermined because not all member states have the capacity to delineate between harmful and total consumption. These trends include the lowest rates of heavy episodic drinking, of underage drinking, and the latest age of first initiative of drinking.

3. Recognition that economic actors in the industry can and do play is working with governments to address harm.

The Australian SAO - Drinkwise - is recognised by government as playing an important contribution in addressing harms in underage consumption, indigenous consumption and warnings around drinking while pregnant, and have staged interventions with measurable results in reduced harmful behaviour. The UNPD explicitly recognised that economic contributors should work with government as a part of the solution, and that they should use their relationships with consumers to provide useful and meaningful information around harm reduction. Additionally, the government has endorsed the co-regulatory model for alcohol advertising and marketing through the Alcohol Beverages Advertising Code, which has a robust and detailed process to minimise the risk of advertising to minors, the regulation of digital marketing, and to prevent irresponsible advertising to consumers.

Economic actors should be incorporated into a whole of society approach to addressing harmful consumption, and not merely noted as an isolated “add-on” to other courses of action.

4. Framework Convention of Alcohol

ABA notes that a framework convention has already been considered and rejected by the Executive Board, and that member states have made clear they do not support this initiative.

5. International Trade

International trade is a responsibility of member states and the remit of the World Trade Organisation, and the action plan should not be making proposals relating to this competency.

Attachment(s): 0

Alcohol Control Policy Network

Country/Location: Kenya

URL: www.kapa.or.ke

Submission

Key comments

1. We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.
2. We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.
3. We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol issues. We further propose to remove two other points in the list of challenges (see detailed description below).
4. The absence of a global, legally binding instrument, leading – among other things – to a lack of protection from alcohol industry interference, is the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).
5. Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.

Attachment(s): 1

00377_38_201207-acpn-submission-who-action-plan-consultation-dec2020.pdf



RE: SUBMISSION FROM ALCOHOL CONTROL POLICY NETWORK

WHO Web based consultation 16 November – 13 December 2020

Working Document to develop an action plan for improving WHO global alcohol strategy implementation

We are grateful for the opportunity to comment on the working document and appreciate the effort by WHO in conducting an ambitious consultative process. We have reviewed the document and have the following comments and suggestions for your consideration.

The Alcohol Control Policy Network (ACPN) is a network of likeminded organizations whose focus is enhancement of Public Health through the reduction of harm caused by alcoholic drinks and substances. ACPN collaborates with partners at the national, county and community level to advocate for the implementation of evidence-based Alcohol policies and programs.

In our submission we will first outline a few key points, then we go on to give more detailed comments and proposals on the different parts of the working document.

Thank you for your consideration.

Yours sincerely,

Philip Gichana

Chairperson

Alcohol Control Policy Network

Key comments

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Detailed comments on the working document

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Regarding Setting the scene

We support the focus on strengthening global action, building on the mandate that Member States have given WHO in 2010 and that Member States have renewed with the WHO governing body decisions in 2019 and 2020.

Concretely, we welcome and support the effort to define clear targets and indicators.

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We welcome and support the analysis of and emphasis on the potential of mainstreaming alcohol policy into other relevant policy sectors and to promote cross-sectorial work to advance alcohol policy development.

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- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

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Objective 8 builds on missing elements contained in WHO GAS objective 4.

Regarding proposed key areas for global action

Broadly, we welcome and support the set of 6 key areas for global action, including the quantity and quality of the actions detailed. Some elements can be improved, some elements are missing, and some elements should be reworked while some others should be removed – as outlined in Movendi International's submission, which we endorse.

We propose to reframe and rework the key areas for global action as “framework for action”, as for example the WHO Global Action Plan for Physical Activity (GAPPA) does. This allows to streamline the actions and create greater coherence across the action areas.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO. Therefore, we propose to include civil society and international partner action in a separate section and to focus Member States and WHO action in the “Framework for action”.

Global action on reporting about alcohol consumption, related harm and policy development should reflect the magnitude and urgency of addressing the alcohol burden. In tobacco control, a global report is launched every year. For alcohol prevention and control that should be the ambition, too.

Role of the alcohol industry

We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. The working document remains incoherent, as is the WHO GAS.

It is critical that the action plan overcomes this incoherence within the frames of the mandate given by Member States through the WHO GAS but in line with a decade of evidence about the alcohol industry's role in delaying, derailing and destroying attempts to implement the WHO GAS.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Regarding improvements to the global governance and infrastructure for alcohol policy development

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitating leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. The reasons are clear and have indirectly addressed in the working document. Therefore, we are convinced that the action plan benefits from including a section about infrastructure and governance improvements – applying lessons learned from other health areas.

Examples of such infrastructure on the level of global action could be:

- A global ministerial conference on alcohol under the guidance of WHO
- A Global Fund for Alcohol Prevention
- A global initiative to advance alcohol taxation
- A functioning international network of alcohol focal points, like there is for NCDs government focal points
- A mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals
- Civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues
- A specific WHO program on alcohol to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called "Infrastructure".

Alcohol Focus Scotland

Country/Location: United Kingdom of Great Britain and Northern Ireland

Submission

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan.

Strengths of the Action Plan include:

- The focus on the 'Implementation of High-Impact Strategies and Interventions' or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.
- The inclusion of an objective focusing on prevention and treatment capacity being an integral part of universal health coverage.

There are also areas where the Action Plan can be strengthened, including:

- Streamlining the global actions actions by avoiding repetition, reducing overlap and adding prioritisation
- Ensuring greater focus on the best buys/SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm
- Addressing the role of economic operators in a separate section of the action plan, making clear their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society
- Having a greater focus on governance and infrastructure improvements, resourcing, as well as commitments to regularly review and to report on implementation.
- Including more reference to alcohol's harm to others. Currently, other than suggesting further research, there is no reference to the impacts of Fetal Alcohol Spectrum Disorder and how to manage them. There are few actions to support families that experience alcohol harm.
- The inclusion of a specific target for Member States to reduce their rate of alcohol-related deaths.
- A more specific focus on Member States increasing the capacity of the alcohol treatment and prevention workforce, which could be achieved by consolidating a number of the actions in areas 2 and 4 under a workforce heading.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and to 'economic operators', which does not clearly articulate the significant

financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.

- An international legal instrument – equivalent to the WHO Framework Convention on Tobacco Control - is required to ensure that WHO's global alcohol policy framework is considered legally binding.

Attachment(s): 1

00272_49_afs-response-who-action-plan-for-gas.pdf



RESPONSE TO THE WORLD HEALTH ORGANIZATION'S CONSULTATION ON THE WORKING DOCUMENT FOR THE DEVELOPMENT OF AN ACTION PLAN TO STRENGTHEN IMPLEMENTATION OF THE GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL

About Alcohol Focus Scotland

Alcohol Focus Scotland (AFS) is Scotland's national charity working to prevent and reduce alcohol harm. We want to see fewer people have their health damaged or lives cut short due to alcohol, fewer children and families suffering as a result of other people's drinking, and communities free from alcohol-related crime and violence.

Introduction

Global leadership on reducing the harmful use of alcohol is essential to achieving improved health and social outcomes for individuals, families and communities across the world. AFS welcomes the opportunity to respond to the World Health Organization's consultation on the working document for the development of an action plan to strengthen implementation of the WHO Global Alcohol Strategy.

Scotland is an international leader in promoting evidence-based alcohol policies. We have a clear national framework for tackling alcohol-related harm at population level, which draws directly on and explicitly references WHO's comprehensive policy action package, SAFER. Yet, despite the commitments and achievements of the Scottish Government's Alcohol Frameworks, including the implementation of minimum unit pricing (MUP) across Scotland in 2018, levels of alcohol harm in Scotland remain high, blighting and shortening many lives.

In 2019, 1,020 people in Scotland died from a cause wholly attributable to alcohol ('alcohol-specific'); contributing to a total of over 10,000 deaths over the past decade.¹ Scotland's alcohol-specific death rate is more than 2.5 times higher than in 1981.² There are also significant inequalities in alcohol-related harm, with those living in the most deprived communities 4.5 times more likely to die³ and six times more likely to be hospitalised than those in the least deprived communities.⁴

These official statistics do not capture even half of the alcohol health harm experienced in Scotland. In addition to health outcomes caused by alcohol alone, alcohol is a causal factor in a further 200 diseases and conditions.⁵ There were an estimated 3,705 deaths attributable to alcohol consumption, equating to 6.5% of the total deaths in Scotland in 2015.⁶

Harm from alcohol also affects others around the drinker including children and other family members, friends, co-workers and the wider community. In addition, alcohol is a drain on our hard-pressed public services and a brake on economic growth, with an annual cost of £3.6 billion.⁷

There is therefore still much work to be done in reducing alcohol-related harm in Scotland and across the world. WHO's leadership and support are vitally important in focusing collective attention on alcohol problems and in encouraging and enabling Member States to take evidence-based action to realise the Global Strategy.

An effective Action Plan is needed to strengthen the Global Strategy

The implementation of the Global Strategy has been uneven across the WHO regions. Between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita. Implementation of the alcohol policy best buy solutions has been insufficient in most countries around the world over the last ten years. Moreover, the alcohol industry has continued to interfere in alcohol policy-making processes. As a result, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, alcohol caused three million deaths worldwide. Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. Without a clear Action Plan, the Global Strategy will remain unrealised and the health, social, economic and development harms of alcohol consumption will remain high and continue to be an obstacle to achieving the Sustainable Development Goals.

An action plan that appropriately and effectively promotes measures to achieve the objectives of the Global Strategy would support AFS's work to achieve a future free from the widespread health and social harm caused by alcohol, and to deliver effective and cost-effective action to reduce alcohol consumption and harm in Scotland and beyond.

In the context of COVID-19, when health services are under strain and alcohol is a risk factor for poorer outcomes, preventative policies such as those in SAFER are needed more than ever.

We have reviewed the Working Document for the development of an action plan to strengthen implementation of the WHO Global Alcohol Strategy (WHO GAS) and have the following comments and suggestions for your consideration.

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan. Strengths of the Action Plan include:

- The focus on the '*Implementation of High-Impact Strategies and Interventions*' or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.
- The inclusion of an objective focusing on prevention and treatment capacity being an integral part of universal health coverage.

There are also areas where the Action Plan can be strengthened, including:

- Streamlining the global actions actions by avoiding repetition, reducing overlap and adding prioritisation
- Ensuring **greater focus on the best buys/SAFER strategies** to ensure that limited resources can be used to have the greatest impact in reducing harm
- Addressing **the role of economic operators** in a separate section of the action plan, making clear their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society

- Having a greater focus on governance and infrastructure improvements, resourcing, as well as commitments to **regularly review and to report on implementation**.
- Including more reference to alcohol's harm to others. Currently, other than suggesting further research, there is no reference to the impacts of Fetal Alcohol Spectrum Disorder and how to manage them. There are few actions to support families that experience alcohol harm.
- The inclusion of a specific target for Member States to reduce their rate of alcohol-related deaths.
- A more specific focus on Member States increasing the capacity of the alcohol treatment and prevention workforce, which could be achieved by consolidating a number of the actions in areas 2 and 4 under a workforce heading.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and to 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.
- An **international legal instrument** – equivalent to the WHO Framework Convention on Tobacco Control - is required to ensure that WHO's global alcohol policy framework is considered legally binding.

We have expanded on the highlighted areas of concern below.

Focus on best buys/SAFER

The numerous and sometimes overlapping recommendations in the draft document tend to obscure a focus on the most cost-effective policies to reduce alcohol-related harms. We consider that a logic model approach, as outlined by the Institute of Alcohol, would be helpful in providing greater structure to the Action Plan. Furthermore, the Action Plan should be strongly framed around every country implementing the 5 most effective, science-based interventions, as articulated in the SAFER guidance:

- Strengthening restrictions on alcohol availability;
- Advancing and enforcing drink driving counter measures;
- Facilitating access to screening, brief interventions, and treatment;
- Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship, and promotion; and
- raising prices on alcohol through excise taxes and pricing policies.

The monitoring indicators should include specific metrics of SAFER implementation, and countries' reporting of the implementation of SAFER policies should be facilitated, especially in LMICs, which currently lack adequate resources and are subject to interference from commercial interests.

The role of economic operators

AFS is concerned by the inclusion of 'economic operators in alcohol production and trade' – i.e. producers, distributors, retailers and marketers of alcohol products – as stakeholders with equal standing in the working document, alongside civil society, academics, international organisations and major partners within the UN system. These economic operators have a clear conflict of interest when it comes to the majority of actions identified by the action plan. To include them as stakeholders with equal standing in the manner that the working document currently does undermines both the purpose and the feasibility of the action plan.

The suggestion within the working document that economic operators have a meaningful contribution to actions identified within the plan is contradicted by the recognition within the working document of the influence of “powerful commercial interests” in policymaking and implementation as a major challenge to the effective implementation of the Global Strategy to date.

Commercial messaging about alcohol as part of “poorly regulated marketing” is also identified as a challenge to progressing the Global Strategy. In the UK, the invitation for the alcohol industry to voluntarily self-regulate both its marketing and labelling of alcohol products has so far yielded extremely disappointing results. A 2020 report by the Alcohol Health Alliance UK (AHA), for instance, found that more than 70% of labels reviewed still did not include the correct low risk drinking guidelines recommended by the UK Chief Medical Officers (CMO), more than three years after they were updated.⁸ Only 2% of the products of members of the Portman Group – an industry funded “social responsibility body” that considers itself a “leader in best practice” – displayed the correct drinking guidelines.

Research from various countries suggests that alcohol industry self-regulatory advertising codes are subject to under-interpretation and under-enforcement.⁹ Despite the existence of regulatory codes designed to restrict exposure of under-18s to alcohol marketing, children in the UK demonstrate high levels of awareness and familiarity with alcohol brands; a survey of Scottish primary schools found 10 and 11 year olds were more familiar with certain beer brands than leading brands of biscuits, crisps and ice cream.¹⁰ In the UK, current restrictions on content, exposure and enforcement are inadequate when it comes to protecting children and young people from alcohol marketing.¹¹

It is becoming increasingly clear in the UK that the alcohol industry is either unwilling or incapable of voluntarily self-regulating to a standard necessary for the protection of public health when it comes to issues such as alcohol marketing and labelling. It is unclear to us, therefore, what including economic operators as stakeholders with equal standing within the action plan will achieve, particularly since the “invitations” to action aimed at them within the current document simply re-iterate suggestions that the industry self-regulate, or “refrain” from marketing to children and vulnerable populations – something they should already be doing.

It is AFS’s position that the role of economic operators should be addressed in a separate section of the action plan, and their conflict of interests made clear; that the language used to refer to dialogue with the industry in the action plan be reassessed; and that the WHO secretariat should evaluate the effectiveness of its regular face-to-face dialogue with the alcohol industry and the risk that this is seen as legitimising their involvement in alcohol policy.

More regular review and reporting on implementation:

We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to reduce alcohol harm, we support the views of the Global Alcohol Policy Alliance (GAPA), and our partners Eurocare (The European Alcohol Policy Alliance), that there needs to be more detail on accountability and transparency in the action plan, and that the lack of specific time intervals for review and reporting on the implementation of the action plan undermines its feasibility.

We consider that the Director-General could be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs and Action Plan in 2030, a progress report and recommendations for the way forward for reducing alcohol harm through alcohol policy should be submitted to the WHO governing bodies by 2028 at the latest to ensure there is no further delay to proportionately addressing any persistent barriers to progress identified through the course of the Action Plan.

International legal instrument

The working document notes that there is currently no equivalent to the WHO Framework Convention on Tobacco Control for alcohol – i.e. there is no international regulatory instrument to ensure that WHO's global alcohol policy framework be considered legally binding – and that this presents a major challenge for the development and implementation of effective alcohol policies globally.

SHAAP endorses the position of our partners at Eurocare (The European Alcohol Policy Alliance): that the continuing absence of legally binding regulatory instruments when it comes to global alcohol policy is an impediment to the successful implementation of the Global Strategy, and that this needs to be addressed at an intergovernmental level.

¹ Giles, L. & Richardson, E. (2020). [Monitoring and Evaluating Scotland's Alcohol Strategy: Monitoring Report 2020](#). Edinburgh: Public Health Scotland.

² Giles, L. & Richardson, E. (2020). [Monitoring and Evaluating Scotland's Alcohol Strategy: Monitoring Report 2020](#). Edinburgh: Public Health Scotland.

³ Information Services Division (2019). [Alcohol-Related Hospital Statistics Scotland 2018/19](#). NHS National Services Scotland.

⁴ Giles, L. & Richardson, E. (2020). [Monitoring and Evaluating Scotland's Alcohol Strategy: Monitoring Report 2020](#). Edinburgh: Public Health Scotland.

⁵ Shield, K. D., Parry, C., & Rehm, J. (2014). Chronic diseases and conditions related to alcohol use. *Alcohol research: current reviews*, 35(2), 155.

⁶ Tod, E. et al. (2018). [Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland](#). Edinburgh: NHS Health Scotland.

⁷ York Health Economics Consortium, University of York (2010). *The Societal Cost of Alcohol Misuse in Scotland for 2007*. Edinburgh: Scottish Government Social Research.

⁸ Alcohol Health Alliance UK (2020). *Drinking in the Dark: How alcohol labelling fails consumers*. London: AHA. <https://ahauk.org/wp-content/uploads/2020/09/DRINKING-IN-THE-DARK.pdf>

⁹ Noel, J. K., Babor, T. F., & Robaina, K. (2017). Industry self-regulation of alcohol marketing: a systematic review of content and exposure research. *Addiction*, 112(S1), 28-50; Noel, J. K., & Babor, T. F. (2017). Does industry self-regulation protect young people from exposure to alcohol marketing? A review of compliance and complaint studies. *Addiction*, 112(S1), 51-56; Noel, J. et al. (2017). Alcohol industry self-regulation: who is it really protecting? *Addiction*, 112(S1), 57-63.

¹⁰ Alcohol Focus Scotland, Alcohol Concern, Balance North East and Drink Wise (2015). *Children's Recognition of Alcohol Branding*. https://www.alcohol-focus-scotland.org.uk/media/62890/Children_s_Recognition_of_Alcohol_Marketing_Briefing.pdf

¹¹ Alcohol Focus Scotland (2017). *Promoting Good Health from Childhood: Reducing the impact of alcohol marketing on children in Scotland*. Glasgow: Alcohol Focus Scotland.

Alcohol Health Alliance UK

Country/Location: United Kingdom of Great Britain and Northern Ireland

URL: www.ahauk.org

Submission

The AHA is an alliance of over 50 organisations from across the United Kingdom. We welcome the opportunity to respond to this working document. We agree that an effective action plan is essential to strengthen the implementation of the global strategy. We suggest some improvements to the document, including: streamlining the content, increasing the focus on some of the areas covered, and changing the approach to others.

Attachment(s): 1

00343_18_aha-who-gas-ap.pdf

Alcohol Health Alliance UK response to the WHO Global Action Plan

We welcome the opportunity to respond to the Working Document for the development of an action plan to strengthen implementation of the WHO Global Alcohol Strategy (WHO GAS). We have the following comments and suggestions for your consideration.

The Alcohol Health Alliance UK (AHA) is an alliance of more than 50 organisations from across the United Kingdom. Our members include medical royal colleges, large charities such as Cancer Research UK, and organisations that provide services to individuals and families. We work together to support evidence-based policies to address alcohol harm. We have included our full list of members at the end of this submission.

Target 3.5 of the United Nations Sustainable Development Goals 2030 includes the objective of strengthening the prevention and treatment of substance use, including the harmful use of alcohol. The vision behind the *2010 Global Strategy to Reduce the Harmful Use of Alcohol* is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to alcohol and the ensuing social consequences.

Alcohol has enormous consequences for the UK, as illuminated in the recent report from the Commission on Alcohol Harm: '[It's everywhere – alcohol's public face and private harm](#)'. This is shown in the statistics, with an estimated 80 people dying of an alcohol-related cause every day in the UK; but also by the personal stories of individuals who have been harmed by alcohol – from their own drinking or the consumption of those around them.

An effective Action Plan is needed to strengthen the Global Strategy

The implementation of the Global Strategy has been uneven across the WHO regions. Between 2010 and 2018, no tangible progress was made in reducing total global alcohol consumption per capita. Implementation of the alcohol policy best buy solutions has been insufficient in most countries around the world over the last ten years. The alcohol industry has continued to interfere in alcohol policy-making processes. Therefore, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, alcohol caused three million deaths worldwide. Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. Without a clear Action Plan, the Global Strategy will remain unrealized and the health, social, economic and development harms of alcohol consumption will remain high and continue to be an obstacle to achieving the Sustainable Development Goals.

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan. Strengths of the Action Plan include:

- The focus on the 'Implementation of High-Impact Strategies and Interventions' or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.

- The inclusion of an objective focussing on prevention and treatment capacity being an integral part of universal health coverage although we would urge the further consideration of innovative and effective options for treatment, such as alcohol care teams, and the mechanisms to support their implementation.

There are also areas where the Action Plan can be strengthened, including:

- Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization
- Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm
- Dealing with the alcohol industry in a single paragraph due to their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does.
- Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation. In action area 3 we recommend reference to 'clinical leads or champions', or similar roles, to provide clinical leadership for the implementation of national and regional efforts to provide effective treatment and prevention.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use, and 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.
- Including more reference to alcohol's harm to others. Currently, other than suggesting further research, there is no reference to the impacts of fetal alcohol spectrum disorder and how to manage them. There are few actions to support families that experience alcohol harm.
- The inclusion of a specific target for Member States to reduce their rate of alcohol-related deaths.
- A more specific focus on Member States increasing the capacity of the alcohol treatment and prevention workforce, which could be achieved by consolidating a number of the actions in areas 2 and 4 under a workforce heading.

The UK would benefit from a number of the policies supported by the action plan: the UK Government lacks a comprehensive alcohol strategy; has regularly introduced real-terms cuts to the rate of alcohol duty; and lacks effective regulation of alcohol marketing. While excellent progress has been made in some parts of the UK – such as the introduction of minimum unit alcohol pricing in Scotland and Wales, far more needs to be done. The evidence-base the WHO provides, for example the best-buys, are exceptionally valuable in our work.

AHA Members

Academy of Medical Royal Colleges

Action on Addiction

alcoHELP

Alcohol Action Ireland

Alcohol Change UK

Alcohol Focus Scotland

Association of Directors of Public Health

Balance North East

British Association for the Study of the Liver

British Liver Trust

British Medical Association

British Society of Gastroenterology

Cancer Research UK

Centre for Ageing Better

Centre for Mental Health

Change, Grow, Live

Changing lives

Drs in Unite

Druglink

Faculty of Dental Surgery

Faculty of Occupational Medicine

Faculty of Public Health

Foundation for Liver Research

Humankind

Institute of Alcohol Studies

Medical Council on Alcohol

Men's Health Forum

National Addiction Centre

National Organisation for FASD UK

Public Health Action

Royal College of Anaesthetists

Royal College for Emergency Medicine

Royal College of General Practitioners

Royal College of Midwives

Royal College of Nursing

Royal College of Physicians of Ireland

Royal College of Physicians London

Royal College of Physicians and Surgeons, Glasgow

Royal College of Psychiatrists

Royal College of Surgeons of Edinburgh

Royal College of Surgeons of England

Royal Society for Public Health

Scottish Families Affected by Alcohol and Drugs

Scottish Health Action on Alcohol Problems

SMMGP & FDAP

Society for the Study of Addiction

SPECTRUM Research Consortium

Spinal Injuries Association

Turning Point

Violence and Society Research Group

We Are With You

Welsh Association for Gastroenterology and Endoscopy

World Cancer Research Fund

Yorkshire and Humber Public Health Network

Alcohol Healthwatch

Country/Location: New Zealand

URL: <http://www.ahw.org.nz/>

Submission

Alcohol Healthwatch is an independent charitable trust in Aotearoa New Zealand working to reduce alcohol-related harms and inequities. We applaud the World Health Organization's commitment to proceed with the consultation on the development of an Action Plan (2022-2030) to implement the Global Strategy to Reduce the Harmful Use of Alcohol. Here is our submission to the Working Document. In brief, our recommendations cover the following areas. Please refer to our submission document for more information.

- The equity lens must be more explicit throughout the Working Document
- Prioritise the three 'Best Buys' in SAFER to achieve the greatest equity gains
- Preventing and reducing inequities in Fetal Alcohol Spectrum Disorder
- Requirement for Member States to have a designated 'home' for alcohol control in government services
- Prioritising the protection of the child. Member States should commit to advocating to schools to implement evidence-based alcohol harm reduction education resources and undertake activities to review programmes associated with the alcohol industry.
- Commercial actors should be addressed separately in the Working Document
- The Working Document should put in place a set of guidelines similar to Article 5.3 of the WHO Framework Convention on Tobacco Control
- Strengthen the provisions of the WHO Framework for Engagement with Non-State Actors (FENSA), by including specific reference to alcohol as well as improving the implementation of FENSA
- An international treaty on alcohol control is inevitable and should be prioritised
- Earmarked funding from alcohol tax revenues in Global target 6.2
- More regular reporting on the implementation of the Action Plan
- WHO Secretariat should prioritise leadership on alcohol and cancer awareness
- In many countries, per capita consumption is not a sound measure. Member States should be encouraged to continually update the assumptions that underpin per capita alcohol measurement
- Normalisation of alcohol use

Attachment(s): 1



Submission to the World Health Organization on the ‘Working Document for development of an Action Plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol’

9 December 2020

Alcohol Healthwatch is an independent charitable trust in Aotearoa New Zealand working to reduce alcohol-related harms and inequities. We are contracted by the Ministry of Health to provide a range of regional and national health promotion services. These include: providing evidence-based information and advice on policy and planning matters; coordinating networks and projects to address alcohol-related harms, such as alcohol-related injury, Fetal Alcohol Spectrum Disorder and supply to minors; and coordinating or otherwise supporting community action projects.

Thank you for the opportunity to provide feedback on the Working Document for the development of an Action Plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

If you have any questions on the comments we have included in our submission, please contact:

Dr Nicki Jackson
Executive Director
Alcohol Healthwatch
P.O. Box 99407, Newmarket, Auckland 1149
P: (09) 520 7035
E: director@ahw.org.nz

Introduction

1. Alcohol Healthwatch applauds the World Health Organization's commitment to proceed with the consultation on the development of an Action Plan (2022-2030) to implement the Global Strategy to Reduce the Harmful Use of Alcohol.
2. Alcohol use remains prevalent in many countries, with global projections forecasting an increased prevalence.¹ In Aotearoa New Zealand, the prevalence of drinking is high, with around 81% of adults (aged 15+ years) reporting past-year use in 2019/20.
3. A notable change over the last decade has been the increase in women's drinking in Aotearoa New Zealand, particularly among population groups that were majority abstainers. For example, whilst more than one-half of Asian women and Pacific women reported abstaining from past-year drinking in 2011/12, more than one half reported past-year drinking in 2019/20.²
4. There has been little change in the overall prevalence of hazardous drinking in Aotearoa New Zealand. In 2019/20, 20.9% of the total population of adults aged 15+ years were classified as hazardous drinkers (AUDIT score ≥ 8).² Hazardous drinking prevalence remains highest among young adults aged 18-24 years old (36.8% males, 27.9% females).²
5. Whilst adolescents have shown positive changes with a lower prevalence of hazardous drinking, significant increases in hazardous drinking have been found among middle-aged to older adults.
6. Māori (Aotearoa New Zealand's indigenous population) experience substantial inequities in hazardous alcohol use. In 2019/20, 43.7% of Māori men were hazardous drinkers, compared to 34.3% of Pacific men and 31.4% among European/other men.² Among women, the differences are even greater, with 29.2% of Māori women reporting hazardous drinking, compared to 16.1% of Pacific women and 14.0% of European/other women.²
7. Among OECD and EU countries, Aotearoa New Zealand has one of the highest rates of youth (15-19 years) suicide.³ There are substantial ethnic inequities in suicide rates in Aotearoa New Zealand, with Māori significantly more likely to die from suicide.⁴ It is clear that alcohol use disorders are a strong risk factor for suicide.⁵
8. In 2019, the third Universal Periodic Review of New Zealand by the Human Rights Council⁶ noted the following:
New Zealand had unacceptably high levels of family violence. One in three women in New Zealand experienced physical, emotional or sexual violence from a partner in their lifetime.
9. Of the recommendations made by the Human Rights Council, many related to addressing violence against women, sexual violence, family and domestic violence and child abuse. Research in Aotearoa New Zealand shows that heavy episodic drinking patterns are associated with more aggression involving alcohol within relationships, and alcohol involvement is associated with increased severity of victimisation.⁷
10. It is clear that strong actions taken on alcohol can assist to reduce the suffering in Aotearoa New Zealand from high rates of suicide and violence. The WHO can, and should, assist Aotearoa New Zealand in this regard.
11. The COVID-19 pandemic has many substantial implications for alcohol use, with impacts likely to be both immediate and long-term.⁸ The longer term impacts are believed to include a normalisation of home drinking, reinforcing or introducing drinking as a way to self-medicate

symptoms of stress, anxiety, boredom and an increased prevalence of newly diagnosed patients with alcohol use disorders (as well as relapse among persons with a disorder).⁹⁻¹³

12. Many people will use alcohol to cope with the on-going impacts of the pandemic. Research shows that individuals who drink for coping reasons are at a heightened risk of developing problems with alcohol.¹⁴ Depression and anxiety have been found to be associated with drinking to cope.¹⁴ Factors such as unemployment, time spent unemployed, redundancy, increased workloads and reduced workplace morale due to loss of staff are also likely to result in a heightened vulnerability to developing new, or exacerbating existing, alcohol-related problems.¹⁵
13. The global health pandemic has the potential to increase alcohol harm inequities. This is already evident in the Aotearoa New Zealand context, with a larger proportion of Māori drinking more heavily post lock-down when compared to pre lock-down (22%), in comparison to other ethnic groups (Pasifika 10%, non-Māori/non-Pasifika 13%).¹⁶
14. Strong, evidence-based actions, free from alcohol industry interference, are required to prevent and reduce inequities during these challenging times.

Recommendations

a) The equity lens must be more explicit within the Working Document

15. We believe that the Working Document requires a stronger equity lens, that is embedded and made explicit throughout. All decisions and actions (by Member States and others) must consider and plan for equity from the outset.
16. As described above, Māori are significantly more likely to drink hazardously than non-Māori and experience substantially greater life loss from alcohol.¹⁷ Māori are disproportionately harmed from living in close proximity to alcohol outlets¹⁸ and Māori children are five times more likely to be exposed to alcohol marketing than European children in their everyday lives.¹⁹
17. The inadequate partnership with, and protection of, Māori with respect to alcohol-related harm is currently the subject of a claim filed with the Waitangi Tribunal. This claim asserts that by failing to implement effective policies the Government is in breach of Te Tiriti O Waitangi (the Treaty of Waitangi) which was signed by Māori chiefs and the Crown in 1840.
18. Whilst the Working Document notes the equity gap of implementing effective alcohol policies between low-income and high-income countries, we also wish to signal the substantial inequities in drinking and harm that exist within countries.
19. We urge the WHO to honour its commitment to improving indigenous health, by including actions and indicators that explicitly address equity. For example, the proposed actions for Member States should include the following:
 - a. Action Area 2 (Advocacy, awareness and commitment): When Member States produce national reports on alcohol consumption and alcohol-related harm, progress towards equity must be measured and reported.
 - b. Action Area 5 (Knowledge production and information Systems): When Member States collect national data on alcohol use and harm, an equity lens must be built into the data

collection process. Equity indicators are of paramount importance. Knowledge production should honour and promote indigenous knowledge systems to gather data on alcohol use and harm. In Aotearoa New Zealand, a lack of equity-specific data and knowledge generation has contributed to entrenched inequities in alcohol harm (especially between Māori and non-Māori). If equity is not measured, then it can't be improved.

- c. Action Area 6 (Resource mobilisation): Resource distribution must seek to restore power and resources to the people and communities who have been most harmed. In Aotearoa New Zealand, developments are needed that ensure Māori have control over the strategies used, and managing and delivering their own services whilst working in partnership with the State. Earmarking funding from alcohol taxes should be utilised to restore power and resources.
 - d. Action Area 3 (Partnership, dialogue and co-ordination): Indigenous populations must be visible in the plan and specifically described as mutual partners with the State, and not rendered invisible by being subsumed into a list of stakeholders to engage in relevant processes.
20. An equity assessment should consider the impact of interventions and policies to reduce alcohol-related inequities, the gaps in knowledge to be addressed, the needs and values of groups experiencing inequities, the plan for partnership with groups disproportionately harmed as well as monitoring and evaluation by equity.
 21. An equity and human rights approach must also explicitly recognise and address the relationship between racial discrimination and alcohol use. In the report of the third Universal Periodic Review of New Zealand by the Human Rights Council⁶, the following was noted:
The impacts of colonization continued to be felt, through entrenched structural racism and poorer outcomes for Māori.
 22. Research in Aotearoa New Zealand found that adolescent students who had experienced ethnic discrimination were more likely to report an episode of binge drinking in the past four weeks.²⁰
 23. Among Māori adults, experiencing discrimination was found to be significantly associated with elevated levels of hazardous alcohol use.²¹ Mediation analysis revealed that 35% of the effect of Māori ethnicity on hazardous drinking could be acting through experience of discrimination.
 24. It is clear that racism is a social determinant of health inequities. The WHO needs to play a key role in transforming institutional racism. The Working Document must recognise the role of racism and include strong efforts by Member States to address it.

b) Prioritise the three 'Best Buys' in SAFER to achieve the greatest equity gains

25. We recommend that the Working Document needs to highlight more clearly, and focus on, the most cost-effective policies to reduce alcohol-related harms (and their inequities), especially in the section on 'Key areas for global action'.
26. In particular, high-impact actions need to be developed and prioritised by Member States that:
 - Increase the price of alcohol
 - Reduce availability of alcohol; and
 - Restrict the marketing of alcohol.

27. The above strategies offer the greatest potential to prevent and reduce inequities in alcohol-related harms. The implementation of these requires monitoring and reporting.
28. We further recommend that the Action Plan be strongly framed around every country implementing the five most effective, science-based interventions, as articulated in the SAFER guidance.
29. The monitoring indicators should include specific metrics of SAFER implementation, and countries' reporting on the implementation of SAFER policies should be supported, especially in Low and Middle Income Countries (LMIC), which currently lack adequate resources and are often subject to interference from commercial interests.

c) Preventing and reducing inequities in FASD

30. We believe that Fetal Alcohol Spectrum Disorder (FASD), as a leading cause of preventable disability, should be explicitly recognised within the Working Document. The negative impacts on the brain and body of individuals prenatally exposed to alcohol lead many individuals with FASD to experience significant challenges in their daily life. Many will need support with motor skills, physical health, learning, memory, attention, emotional regulation, and social skills.
31. Research studies have shown that:
 - between 10-20% of people in prisons and other correctional settings have an FASD.²²
 - around 80% of adults with an FASD will not be able to live independently without some level of support.²³
 - children and adolescents with an FASD have a 95% lifetime likelihood to experience mental health issues.²⁴
 - people with FASD have a higher risk (up to five times greater) of suicidal behaviour than the general population.^{23,25,26}
 - life expectancy of people diagnosed with Fetal Alcohol Syndrome under the International Classification of Disease (ICD) have a shockingly low life expectancy of 34 years on average. The leading cause of death were external causes, with 15% of these being death by suicide.²⁶
32. FASD remains a "hidden disability" and must be given greater attention in our global efforts to reduce inequities in alcohol-related harm. Preventing FASD and reducing its associated secondary harms is imperative and efforts must be visible within the Working Document.
33. National alcohol policies must include evidence-based actions to prevent FASD and its secondary harms. This includes research on prevalence, provision of early diagnosis, delivery of FASD-informed care across sectors, and on-going and sufficient support for individuals and families living with FASD.
34. We recommend that Action Area 2 (Action 2 for Member States) be expanded to include:
 - National alcohol policies should include evidence-based actions to prevent FASD and its secondary harms.
35. Diagnosis before the age of six years is identified as a protective factor associated with a lower likelihood of experiencing secondary harms from FASD.²⁷ However, in Aotearoa New Zealand diagnostic services for FASD are rarely accessible and often very costly.

36. Failure to provide for early identification denies the individual and wider family the knowledge on which to build strength-based early intervention, thereby furthering inequities. Much of the harms from FASD could be ameliorated by appropriate early intervention that is guided by the individual diagnosis.
37. We therefore recommend that Action Area 4 (Technical support and capacity building) for Member States should expand beyond actions for health professionals to identify and manage hazardous drinking and disorders, to include:
- Develop and strengthen the capacity of multi-disciplinary health services teams to diagnose Fetal Alcohol Spectrum Disorder.
38. Furthermore, adequate training is required across the health, education, care and protection, and justice systems to enable safe and appropriate treatment of individuals with FASD. Without this training and resulting understanding of what works best, FASD harms continue to occur as individuals are misdiagnosed, misunderstood and mistreated.
39. We therefore recommend that Action Area 4 (Technical support and capacity) for Member States includes the following:
- Develop and strengthen the capacity across sectors to deliver FASD-informed care.
40. Support is also required for individuals and families living with FASD. Children and young people who receive a diagnosis must have a clear pathway for support under an umbrella of disability services. We therefore recommend that Action Area 6 (Resource mobilisation) requires that Member States:
- Increase allocation of sufficient resources to support individuals and families living with FASD.
41. Finally, we commend the WHO for initiating the International Collaborative Research Project on Child Development and Prenatal Risk Factors with a focus on FASD to help gain a better understanding of its prevalence, severity and impact. In Aotearoa New Zealand, there has been no population-based prevalence study of FASD. We recommend that Action Area 5 (Knowledge production and information Systems) include the following:
- *Actions for the WHO Secretariat:* Further develop the International Collaborative Research Project on Child Development and Prenatal Risk Factors (with a focus on FASD), and promote and support Member States to conduct a FASD population-based prevalence study.
 - *Actions for Member States:* Support the implementation of the WHO-initiated population-based FASD prevalence study.

d) Requirement for Member States to have a designated ‘home’ for alcohol control

42. We commend the WHO for proposing that Member States increase allocation of resources to reduce harmful alcohol use. However, we believe that stronger actions need to be proposed that require Member States to have a dedicated ‘home’ for alcohol control in government services.
43. The New Zealand Government Inquiry into Mental Health and Addiction noted the following with regards to leadership on alcohol control in Aotearoa New Zealand²⁸:

Alcohol and other drug policy does not have a clear home within government

Central Government appears to have lost traction on alcohol and other drug issues, although we note the recent formation of a cross-party group on drug harm reduction. Overall, leadership is weak and it is unclear where responsibility for coordinated strategy and policy lie.

Given the significant role that alcohol and other drugs play in people's wellbeing across New Zealand, a unit with a strong cross-sectoral focus dedicated to advancing alcohol and other drug policy is critical.

44. Given the magnitude of harm and inequities, commitment to leadership and stewardship on alcohol control is essential. This is recommended in the Global Alcohol Strategy to reduce Harmful Alcohol Use.²⁹

e) Role of economic actors

45. We agree with others that there is a fundamental and irreconcilable conflict between imperative shareholder value maximisation and public health policy interests.³⁰ In the words of the former WHO Director-General Margaret Chan, "efforts to prevent non-communicable disease go against the business interests of powerful economic operators".³¹
46. It is clear in the Working Document that the WHO recognises industry's "interfering with alcohol policy development and evaluation". However, we believe that the proposed actions for the commercial actors are too weak to be effective.
47. A thematic and content analysis of industry submissions to the Department of Foreign Affairs and Trade in Australia found that the industry is actively seeking to shape trade negotiations around alcohol issues. Priority issues for the industry include improving market access, harmonising regulation, improving clarity and transparency, reducing the burden of regulation and preventing monopolies on product names.³² These issues run counter to the protection of public health and reduction in inequities.
48. Also in Australia, it was found that the draft national alcohol strategy was watered down following industry consultation.³³
49. In Aotearoa New Zealand, the supermarket duopoly has regularly appealed local government efforts to limit alcohol outlet density and reduce trading hours. Community wishes for greater control over licensing decisions have been totally over-shadowed by the legal resources of the alcohol retailers.³⁴
50. More notably, the alcohol industry has used corporate philanthropy as a strategy to divert public attention from less altruistic practices (marketing, lobbying, avoidance of stricter regulations, etc.) and rather shape their corporate image to being trusted, caring, socially responsible and even healthy³⁵
51. In Aotearoa New Zealand, this is evident from an increasing number of alcohol industry partnerships with cancer, mental health, wellbeing and environmental charities.

i. Prioritising the protection of the child

52. Of particular concern has been the international dissemination of 'Smashed' and other industry-funded school-based education programmes. As an example, 'Smashed' commenced in the

United Kingdom in 2005 and to date has engaged more than half a million students internationally.³⁶

53. These programmes are directed at very young students; an age group that has heightened vulnerability to alcohol-related harm. The teaching resources of the ‘Smashed’ ‘responsible drinking’ programme have been critiqued and published in a peer-reviewed journal³⁶, with an accompanying editorial.³⁷ The involvement of schools in alcohol industry-funded education has the potential to do more harm than good, especially if it replaces the teaching of evidence-based harm reduction materials in the class and has the effect of delaying the implementation of strong alcohol policies.
54. We believe the following statement in the Working Document needs to be addressed by Member States:

“Economic operators.....are invited to...refrain from engagement in capacity-building activities outside of their core roles that may compete with the activities of the public health community.”
55. We are in agreement with Ireland’s Health Minister³⁸ and Education Minister³⁹ on the need to separate out the alcohol industry from being part of the conversation, with the former stating that “it’s completely and utterly bizarre that you’d have a body funded by the drinks industry educating our kids about the dangers of alcohol... I mean it’s ridiculous” (para. 3).³⁸
56. The commercial determinants of health have also been raised as a children’s right issue. Earlier this year, the WHO-UNICEF-Lancet Commission called for the development of a new protocol to regulate against commercial harm to children.⁴⁰ The protocol is an optional instrument to the UN Convention on the Rights of the Child.
57. The rationale for developing such a protocol is the recognition of the growing threat of the commercial sector to child health and wellbeing. This includes the ubiquitous presence of alcohol advertising (including digital communications) and exposure to industry-funded education in their schools, both serving to undermine their health and wellbeing.
58. We therefore recommend that the Working Document include the following under Area Action 2 (Advocacy, awareness and commitment) for Member States:
 - Commit to advocating to schools to implement evidence-based alcohol harm reduction education resources and undertake activities to review programmes associated with the alcohol industry.

ii. Commercial actors should be addressed separately in the Working Document

59. Given the above, we are very concerned to see in the Working Document that alcohol industry entities are listed as stakeholders with equal standing alongside civil society and other UN organisations. This is inappropriate, given their explicit conflict of interest and long record of opposing effective alcohol policies, not only in Aotearoa New Zealand but right across our Western Pacific region and beyond.
60. The alcohol industry should not be included as an ‘equal’ with non-commercial interests but rather, be addressed in a separate section with due regard to their conflict of interest with respect to public health. For example, the structure of the action statements includes a role for economic operators as if they are equivalent to other non-state actors. We oppose this.

61. In 2018, the report of the New Zealand Government Inquiry into Mental Health and Addiction noted the role of commercial actors and stated the following²⁸:

Despite alcohol's harm, New Zealand has a normalised heavy drinking culture that, by and large, does not recognise current alcohol use as a crisis. Strong vested interest groups have incentives to resist change. We see parallels with tobacco control and smoking, and believe a similar approach will be needed to tackle the harmful use of alcohol.

62. In 2018-2020, the New Zealand Government commissioned an independent review into the health system to determine recommendations for system-level changes that would be sustainable, lead to better and more equitable outcomes for all New Zealanders and shift the balance from treatment of illness towards health and wellbeing. The final report noted the following with regards to the commercial drivers of ill health⁴¹:

Faced with growing challenges from NCDs, the Review is clear that there is a need for much more concerted action at national, regional and local levels to address the commercial determinants of health.

63. We strongly believe that international plans and strategies can provide countries, such as Aotearoa New Zealand, the explicit provision and mandate to address the commercial determinants of health.

64. In agreement with the submission from the Health Coalition Aotearoa, we do not support action statements being structured as invitations to economic operators to act against their own commercial interests by voluntarily adopting effective strategies to reduce consumption and harm; for example, to eliminate marketing and promotion of drinking. This does not represent evidence-based intervention. Equally, we are also concerned that civil society actors are “invited” to provide all proposed monitoring and countering of industry influence, which we see as part of any global action.

65. We recognise that the Working Document refers to economic operators ceasing funding research for lobbying purposes. We strongly believe that this needs to be stronger and clearer or it will be seen as an opportunity to instead increase sponsorship of activities that encourage ineffective interventions. That is not acceptable. We recommend that a better approach might be to provide guidance to civil society and academia not to enter into formal or informal partnerships with industry and underline that alcohol industry funding not be accepted.

66. Further, in the absence of a legally binding health treaty (discussed next), Member States should be encouraged to adopt measures to increase transparency of commercial influence in policy making. Member States could be advised to:

- Develop explicit agreements or protocols regarding engagement with commercial stakeholders on alcohol policy issues;
- Monitor media coverage of industry-related issues as well as industry websites;
- Identify state-funded organisations and activities sponsored by those with alcohol industry interests;
- Develop and implement regulations that require commercial operators to submit sales data as well as marketing data; and
- Develop ‘cooling down’ or ‘revolving door’ legislation to ensure high-level political insiders can’t simply shift straight into jobs lobbying the government (and vice versa).

f) An international treaty on alcohol control is inevitable and should be prioritised

67. As described in the Working Document, alcohol remains the only psychoactive substance that lacks legally-binding regulatory instruments at the international level.⁴²
68. The current process of developing an Action Plan provides an important and timely opportunity, especially for fostering deliberation of a more effective instrument as well as strengthening the global governance of alcohol.⁴³
69. We believe that a stronger global plan and a legally binding framework, akin to the Framework Convention on Tobacco Control (FCTC), are urgently needed to support individual Member States to withstand the industry's opposition to regulation, and to prioritise action on alcohol, as has been advocated previously.
70. Most importantly, the WHO and Member States need to demonstrate strong leadership in advancing the global governance of alcohol control.
71. It is imperative to have a codified international instrument to help Member States, especially low-income countries, to protect population health. There is a growing inadequacy for domestic law and regulations to attain public health objectives at the country level.
72. This is especially in relation to the proliferation of digital advertising, particularly on social media platforms. Collaboration between countries and social media enterprises is necessary to address emerging marketing tactics employed by multi-national firms on digital platforms. A legal framework for alcohol control is an important step towards reducing harm from digital marketing.
73. Also of relevance is Action 6 (in Action Area 2) proposing that Member States ensure appropriate consumer protection measures through development and implementation of labelling requirements for alcoholic beverages. As witnessed in Canada, legal threats are mounted in relation to labelling, particularly for cancer warning labels.⁴⁴
74. Without a legal health treaty, legal challenges and litigation continue to impose a chilling effect on governments to implement effective alcohol policies and interventions. It took more than 20 years of strong advocacy in Australia and Aotearoa New Zealand to ensure an evidence-based alcohol pregnancy warning label is placed on alcohol products.⁴⁵ It is incredible to comprehend the suffering by individuals and families across Aotearoa New Zealand and Australia that could have been prevented from earlier implementation of a warning label.
75. It is clear that trade and economic agreements have become a legal tool manipulated by the alcohol industry to undermine public health measures. Below are some examples:
- The Alcohol Minimum Pricing Bill (passed by the Scottish Parliament in 2012) was challenged by the alcohol industry under EU single market law. The industry challenged the compatibility of the proposed bill at the time with the EU law. This included a claim that the Scottish legislation could constitute a quantitative restriction on trade and distort competition among alcohol distributors.⁴⁶
 - Alcohol marketing and advertising restrictions introduced in France, known as 'The Loi Evin', were challenged by the alcohol industry stakeholders in the European Court.⁴⁷

76. We believe that lessons can be drawn from the Framework Convention on Tobacco Control. The negotiation process of the WHO FCTC facilitated multilateral collaboration on aspects of tobacco control that transcended national boundaries. It also promoted national action and international co-operation.⁴⁸
77. Since the WHO FCTC came into force in 2005 (after the 40th member state had ratified the treaty), the Conference of the Parties has become a venue for Member States to collaborate, deliberate on tobacco control policies, and develop new guidelines and protocols (e.g. Guidelines on Article 5.3, Protocol on illicit tobacco trade). The WHO FCTC has also advanced the development of domestic law.⁴⁹ It has provided a legal framework for implementation and given government's the authority to act.⁵⁰
78. Lastly, the WHO FCTC has provided legal weight to Member States in times of legal challenges launched by the tobacco industry.
79. In a study of the 96 court decisions concerning legal challenges to tobacco control measures⁵⁰, the WHO FCTC was cited in 45 decisions. Decisions both citing and not citing the WHO FCTC were largely decided in favour of governments, with 80% of WHO-FCTC-citing and 67% of non-WHO-FCTC citing cases upholding the measure in its entirety and on every ground of challenge.
80. As the authors note in the study, it was difficult to 'prove' that the WHO FCTC was directly responsible for the positive outcome of any particular case, despite the higher number of citations in cases that were upheld. Many cases were decided on multiple grounds, each of which alone could be sufficient to dismiss a challenge. A lack of counterfactual, for what would have happened if there was no WHO FCTC, limits determination of causality.⁵⁰
81. However, the WHO FCTC and its guidelines have helped to translate a large and complex body of scientific evidence into a format that is understandable to legal institutions and assimilable to legal concepts. The WHO FCTC has also demonstrated international consensus in support of public health measures and assisted to establish whether or not a measure is reasonable, proportionate or justifiable.⁵⁰
82. We believe that an Framework Convention on Alcohol Control is inevitable. This generation should be leaving a legacy for the next by protecting its rights to be free from alcohol harm and interference from the alcohol industry.
83. Whilst the Framework is in development, we recommend the Working Document put in place a set of guidelines similar to Article 5.3 of the WHO FCTC. See paragraph 66.
84. Further, we support GAPA's position on strengthening the provisions of the WHO Framework for Engagement with Non-State Actors (FENSA), by including specific reference to alcohol as well as improving the implementation of FENSA.

g) In many countries, per capita consumption is not a sound measure

85. Whilst we support consistent measurement in relation to alcohol consumption, we believe that the use of per capita consumption as a Global Target indicator is increasingly becoming out-of-date and meaningless. Alcohol policy decisions must be informed by sound data.

86. Estimates of per capita consumption are usually derived from assumptions regarding the alcohol content of dominant alcohol types. However, over time, alcohol beverages have changed in their average strength (i.e. alcohol by volume).
87. Per capita estimates need to take into account these changes. For example, the alcohol content of table wine has changed considerably over the past few decades.⁵¹ In Aotearoa New Zealand, per capita estimates assume that wine is 11% alcohol strength⁵² and this is likely to be a significant under-estimate.
88. Other countries, such as Australia, have updated their per capita measures to take into account the changes in the alcohol market. Using up-to-date estimates, the per capita alcohol consumption was found to be increasing in Australia; remarkably different to the stable per capita use reported using unadjusted data.⁵³
89. Any reporting of per capita alcohol use needs to acknowledge this significant limitation. Alternatively, we recommend that the Working Document encourages Member States to continually update the assumptions that underpin per capita alcohol measurement.

h) Earmarked funding from alcohol tax revenues in Global target 6.2

90. We support the recommendation to Member States to increase allocation of resources for reducing the harmful use of alcohol and increasing coverage of prevention and treatment interventions.
91. We support the target for ring-fenced funding from alcohol tax revenues and further support Action 1 that provides for Member States to also use other innovative mechanisms to increase funding. This will give more flexibility to Member States to fund prevention and treatment interventions for alcohol use disorders and alcohol-related health conditions. However, we believe earmarked alcohol tax revenue is the ultimate goal.
92. As described previously, we further recommend that within the earmarked funding pool, further earmarking of monies should be made for priority populations. For example, in Aotearoa New Zealand, specific and sufficient funding should be provided to Māori, so that programmes and services can be developed by Māori, for Māori.

i) More regular reporting on implementation

93. In agreement with the submission from the Health Coalition Aotearoa, we are concerned about the lack of specific time periods for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to reduce alcohol harm, we ask that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.
94. In addition, prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

j) WHO Secretariat prioritising leadership on alcohol and cancer awareness

95. We support Action 2 of Action Area 2 (Advocacy, awareness and commitment) for the WHO Secretariat to develop and implement an organisation-wide communication plan to support actions to reduce the harmful use of alcohol, targeting different population groups and using different communication channels.
96. We strongly recommend that the WHO take leadership in increasing communications regarding alcohol-cancer risks.
97. Awareness of alcohol-cancer links in Aotearoa New Zealand remains low. In one study, 13.8% (14.6% females, 12.8% males) of respondents could list (unprompted) alcohol as a risk factor for cancer. In relation to unprompted dietary risk factors for cancer, 40.8% of the respondents listed alcohol as a risk factor (41.8% females, 39.5% males).⁵⁴ Awareness among Māori is unknown.
98. In relation to particular cancers, research shows that New Zealanders have a very low level of awareness of the risk of alcohol use for bowel and female breast cancer.⁵⁵
99. Research shows that knowledge of alcohol-cancer links can produce favourable changes in intentions to reduce consumption⁵⁶, with the bowel cancer warnings producing the most effective results.⁵⁷
100. Furthermore, knowledge of alcohol-cancer links is associated with increased public support for high impact, evidence-based alcohol policies.^{56–59} As such, we believe that strategies to increase awareness of alcohol-cancer links represent an important component of advocacy for the 'Best Buys'.
101. We strongly recommend the WHO include increasing awareness of alcohol-cancer links in the development of the proposed communications plan. Other important issues include the impact of alcohol on mental health and suicide, family violence, reduced child wellbeing, and immunity (in relation to health pandemics).

k) Normalisation of alcohol use

102. We support the submission of the Health Coalition Aotearoa that recommends the Working Document recognise the many cultures (whether based on ethnicity, religion, age or peer group) who have not normalised use of alcohol. In cultures and societies where alcohol is used, this has often traditionally been small scale home production that is now being replaced by commercial alcohol and aggressive marketing by transnational corporations, leading to increased consumption and harm. Especially in LMICs, this is placing huge burdens on governments and NGOs, through social and health services and systems.

Conclusion

103. Strong actions taken to reduce alcohol use and harm can significantly improve the wellbeing of every person in Aotearoa New Zealand, for this generation and the next. In particular, our most vulnerable (children, women, disadvantaged populations) will benefit the most from leadership taken on alcohol.

104. The entrenched inequities in alcohol harm in Aotearoa New Zealand must be prioritised and addressed. In particular, New Zealand must uphold its obligations to Te Tiriti o Waitangi to protect Māori health.
105. By strengthening the Working Document, the WHO can greatly support Aotearoa New Zealand to reduce its shamefully high youth suicide and family violence rates. The possibilities for Aotearoa New Zealand to reach its potential are endless. We all have a duty to act.

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Alcohol Justice

Department/Unit: *Research*

Country/Location: United States of America

URL: www.alcoholjustice.org

Submission

Alcohol Justice has reviewed the Global Strategy to Reduce Harm from Alcohol Use, and offers the following comments in accordance with our own mission:

1. Language needs to more directly engage the alcohol industry as an inevitable roadblock to effective policy, and to acknowledge that alcohol producers and sellers are not the only business entities that benefit from alcohol sales.
2. Product design, not just marketing, is a tool for targeting vulnerable groups and youth, and should be explicitly addressed.
3. Health equity, social justice, and economic justice should be more explicitly acknowledged in the actions. It should be made clear that effective alcohol control must acknowledge indigenous, vulnerable, and/or marginalized communities both within and across member states.
4. The pitfalls of trade agreements must be acknowledged, not just their promises. WHO and member states should shun preemptive language that strips localities of the power to control alcohol harm more strictly as they see necessary.
5. Deregulation itself is a creeping source of alcohol harm, and must be confronted and monitored. At the moment, much of this is happening under the cover of COVID-19 relief.

Attachment(s): 1

00515_33_aj-global-alcohol-strategy-comments-2.pdf



The Industry Watchdog

December 10, 2020

**TO: World Health Organization, Department of Mental Health and Substance Use,
Geneva, Switzerland**

FROM: Alcohol Justice, San Rafael, California, USA

RE: Comments on the draft WHO Global Strategy to Reduce the Harmful Use of Alcohol

Alcohol Justice is an alcohol industry watchdog, alcohol harm prevention advocate, and policy education and analysis organization in the United States. At the urging of the United States Alcohol Policy Alliance and Global Alcohol Policy Alliance (GAPA), we are proposing comments in response to the WHO Global Strategy to Reduce the Harmful Use of Alcohol document released on November 16, 2020. We would like to add our categorical support for the GAPA group's recommendations, and offer our own comments and suggestions.

The request for comment asks that we address the following prompt:

"We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration:"

The guidelines provide an effective and broad roadmap for coordination among various actors within the harm prevention and mitigation space. However, there are several areas in which we feel the WHO does not address concerns facing the global community.

- (1) Although the introductory text identifies transnational alcohol companies as a threat to effective global alcohol control, the action items pay excessive deference to corporations. Global alcohol control cannot be successfully pursued without addressing the central role multinational corporations have in lowering alcohol price points, increasing product distribution, affecting national policies, and using marketing and sponsorships to change cultural norms. The document repeatedly calls for corporate actors to be engaged and brought to the table of their own volition.

The actual behaviors of these companies does not warrant this polite attitude. Ultimately, the wealth and power of multinational alcohol companies requires an adversarial stance. There needs to be explicit guidance to states to monitor, sanction, and restrict the activities of these corporations in action areas 1, 2, 4, 5, and 6.

24 Belvedere Street, San Rafael, CA 94901-4817 • t 415-456-5692 • f 415-456-0491

alcoholjustice.org

Additionally, the WHO, member states, and NGOs should be directly involved in capacity building and material support for monitoring and advocacy groups that directly confront the local and global alcohol industries, especially in low-income countries (LICs) and lower-middle-income countries (LMICs) that would not otherwise have the resources to mobilize on this level. These should be reflected in action areas 4 and 6.

On a more specific level, Action Area 6, Non-State Action 3 needs particular work. As written, it seems contradictory. We strongly agree with the second half of the item: that alcohol industry money should not be used as a direct expenditure for public health, health education, or research. We assume the intention of the first half is to promote indirect spending and blind grants, but experience with the tobacco industry (as well as the alcohol industry's own track record) shows that keeping these funding channels open always leads to distortion of health messaging, misallocation of resources, or overt corruption. If the alcohol industry wants to be involved, they can give unrestricted grants to NGOs. Note also that alcohol industry personnel should be prevented from sitting on the boards or oversight committees of NGOs or other health institutions.

- (2) More broadly, the effort to pivot the recommendations away from regarding the alcohol industry as a useful collaborator and instead confronting them winds through all our subsequent recommendations. The incentives for global alcohol sales are explicitly at odds with alcohol control.
- (3) Action areas 1, 2, and 5 need to more explicitly address youth-oriented product design. There is strong, scientifically reviewed evidence that age of initiation into alcohol use determines severity of alcohol problems later in life. Global alcohol companies have explicitly identified certain products as being intended to appeal to naïve drinkers who do not like the taste of alcohol. Multinational coordination to restrict products such as alcopops, hard seltzers, powdered alcohol, and other heavily flavored or flavor-masked products is essential to controlling the growth of alcohol harm.
- (4) Much of this document—and the SAFER guidelines on which it is based—concerns the strategies to reduce harm from alcohol consumption. It needs to be emphasized that the impacts of alcohol harm are felt at the community level, too. Alcohol profits have been used to fund gross human rights violations. Indigenous or vulnerable communities are harmed by the monopolization of resources in the name of alcohol production. Coordination between state and non-state actors does not address the precarious position of these communities, whose interests can be at odds with both the industry and the nation in which they reside.

It cannot be overstated the importance and power of international coordination and intervention to prevent harm to these communities. Action areas 2, 3, and 6 need to include language that prioritizes the protection of vulnerable groups from both corporate and state exploitation in the name of alcohol profits. NGOs that focus on indigenous rights, resource protections, and human rights issues need to be considered part of the

alcohol harm prevention community and brought to the table in the action areas.

- (5) When engaging corporate actors, such as under Action area 1, proposed actions for international partners and non-State actors Action 3, the perspective needs to broaden to include not just the alcohol industry but entities that rely on alcohol industry money. In particular, this includes sports organizations, leagues, tournament organizers, and academic institutions that generate revenue from alcohol advertising. Alcohol advertising connected to sporting events has been repeatedly demonstrated to increase alcohol use and provide cover for marketing to youth. Many of these organizations are international in scope, and need international engagement and pressure to restrict their appeal to the alcohol industry.
- (6) Free trade agreements and international arbitration provides both pitfalls and opportunities for global alcohol control. On the one hand, preemptive language can be used to hamstring nations' abilities to enact SAFER policies, particularly price controls and taxes. In the United States, there is considerable fear and anticipation that international litigation or complaints will target specific states (such as California) with accusations that they are pursuing stronger laws and regulations than the US Federal government. However, that is exactly how state-level regulatory structures are designed under the 21st Amendment to the United States Constitution. Although the United States is idiosyncratic in many ways, similar jurisdictional issues around alcohol control have emerged within and between EU states. Member States should be urged to recognize and defend the concept of regional (provincial, state, or department) regulation as having the same status as national regulation in international trade agreements. The Secretariat should be establish guidelines for both inter- and intranational policies that defend these regional policies. Member States should be urged to identify and repeal all preemptive legislation that overrides more stringent local alcohol policies and regulations.

That said, international trade agreements can also be used to constrain aggressive alcohol corporations' attempts to exploit new markets, collaborate directly with governments or government entities that commit human rights abuses, and/or monopolize water or land in such a way as to displace indigenous and other vulnerable communities. We recognize that the current outline briefly advocates this strategy in Action Area 3. However, broader action is needed. Member State and WHO Secretariat actions should reflect analysis of existing agreements and the development of new language that serves the needs of alcohol control under Action areas 1 and 5, and consider the use of trade agreement language to fund alcohol control under Action area 6.

- (7) WHO's SAFER goals emphasize alcohol access restrictions to limit use. In many HICs, localities are aggressively pursuing liberalization of licensing policies and, in particular, alcohol trading hours. The section "challenges in implementation of the Global Strategy" should recognize that deregulation, in particular of trading hours, be identified as a

constant threat to effective implementation of the Global Strategy. We also ask that Action Area 5 include policy monitoring of deregulation within member countries as a proposed action by Member States and the Secretariat.

- (8) The section “opportunities for reducing the harmful use of alcohol” identifies the COVID-19 crisis as an influence on alcohol use patterns. However, it largely regards it as a positive in terms of lessons learned. This is incomplete framing, since countries have found themselves allowing an array of novel routes of alcohol purchase as an economic support for businesses. Similarly, in Action area 2, Secretariat action 3 mentions COVID-19 as an emerging challenge, but that should recognize that COVID-19 is enabling and complicating enforcement challenges; that the regulatory reliefs proposed by many states threaten to exacerbate alcohol harm; and that the power of the alcohol corporations have made it politically unpalatable to shutter alcohol outlets and provide direct relief to their employees, instead trying to encourage new alcohol use patterns so that consumers can provide that economic relief through stripping away long-standing alcohol control policies.

We admit that these comments are granular, in contrast to the relatively general roadmap provided in the Global Strategy document. Nonetheless, we want to make sure that the structures built reflect the inequities, power structures, and shifting behavioral patterns in the global alcohol harm environment. Thank you for this opportunity to participate in this important and ambitious project.

Respectfully,



Carson Benowitz-Fredericks, MSPH
Research Manager, Alcohol Justice

Alcohol Policy Futures

Country/Location: Sweden

Submission

We are grateful for the opportunity to comment on the working document and appreciate the effort by the World Health Organization in conducting an ambitious consultative process.

In general, we welcome and support large parts of the working document as elements of the future action plan. But we also see room for improvement and opportunities to strengthen the action plan. Finally we emphasize an element of disagreement with the working document.

What we support

The Working Document provides a sound starting point for the development of an action plan. Strengths of the action plan include:

1. The focus on the 'Implementation of High-Impact Strategies and Interventions' or SAFER strategies,
2. The strengthening of the mandate and case for global and Member States' action,
3. The inclusion of global targets and indicators,
4. The emphasis on alcohol policy mainstreaming and cross-sectorial work to tackle alcohol harms,
5. The acknowledgement of the need to increase resources and to explore innovative ways for resource mobilization required for action,
6. The inclusion of an objective focussing on prevention and treatment capacity being an integral part of universal health coverage,
7. The inclusion of "new" ideas for global actions, such as:
 - a. Awareness day/ week,
 - b. Revising the nomenclature,
 - c. Linking the alcohol burden more clearly to the health system, and
 - d. Technical capacity-building.

What we would like to improve

There are also areas where the action plan can be improved and strengthened, including:

1. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions
2. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization,

3. Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,
4. Dealing with the alcohol industry in a single paragraph,
5. Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation,
6. Changing the way that alcohol use and harm is referred to throughout the document

We disagree with the role assigned to the alcohol industry in the working document

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

Alcohol Policy Futures - APF is a global platform for alcohol policy discussion and joint advocacy to promote the formulation and implementation of evidence-based, high-impact alcohol control measures.

Attachment(s): 1

00506_27_apf-submission-who-working-doc-2020.pdf

Alcohol Policy Futures

Alcohol Policy Futures Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

*WHO GAS = WHO Global Alcohol Strategy

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5. The acknowledgement of the need to increase resources and to explore innovative ways for resource mobilization required for action,
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Alcohol Policy Futures

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4. Dealing with the alcohol industry in a single paragraph,
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6. Changing the way that alcohol use and harm is referred to throughout the document

1. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

We have identified 15 challenges that are listed in the working document. This section is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate.

Not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist and should be explored. Some APF partners explore this in more detail in their individual submissions.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

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2. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

We recognize that this document sets out an ambitious agenda. The high number of actions, that are not always clearly linked to operational objectives or goals, creates the risk that the action plan will become unwieldy and challenging to implement and/or monitor. In order to strengthen the likelihood of the action plan's success, we propose that actions are prioritized based on evidence of effectiveness to encourage efficiency in resource utilization.

A logic model or theory of change approach would help to map how activities produce relevant outputs that lead to outcomes, which in turn help to meet broader goals (see example below).

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Where possible, actions and key indicators should be time-bound.

3. Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions – to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol.

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan. We support the focus on the most cost-effective alcohol policy solutions and suggest to expand their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys – that has largely fallen short of necessity – is currently missing.

4. Dealing with the alcohol industry in a single paragraph

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

5. Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation

Compared to other areas of global health, the governance, infrastructure, resourcing as well as review and reporting of alcohol policy development worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document.

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Governance, infrastructure, resourcing and review and reporting matter for the quality and frequency of discussions, leadership and commitment to alcohol policy development and implementation.

Regarding review and reporting, annual – as in tobacco control – WHO publications about alcohol harm and or policy development are essential, as is the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item.

Regarding resourcing, already in the process of developing the action plan, government should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the global alcohol burden.

Regarding governance and infrastructure, some APF partners suggest concrete improvement in their individual submissions.

6. Changing the way that alcohol use and harm is referred to throughout the document

As stated above, we support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

We disagree with the role assigned to the alcohol industry in the working document

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

Alcohol Policy Futures

On behalf of Alcohol Policy Futures

1. Alcohol Action Ireland
2. Alcohol Control and Policy Network (ACPN), Kenya
3. Alcohol and Drug Information Center (ADIC), Sri Lanka
4. European Alcohol Policy Alliance (Eurocare)
5. FORUT Norway,
6. Foundation for Alcohol Research and Education (FARE), Australia
7. Global Alcohol Policy Alliance
8. Institute of Alcohol Studies (IAS), UK
9. IOGT-NTO, Sweden
10. Movendi International
11. Scottish Health Action on Alcohol Problems (SHAAP), Scotland
12. Serenity Harm Reduction Program Zambia (SHARPZ), Zambia
13. Southern African Alcohol Policy Alliance (SAAPA)
14. Stop Drink Network, Thailand
15. Student Campaign against Drugs (SCAD), Kenya
16. Uganda Alcohol Policy Alliance (UAPA)
17. Youth against Alcoholism and Drug Dependence (YADD), Zimbabwe

Alko

Country/Location: Finland

URL: www.alko.fi

Submission

As alcohol is not an ordinary commodity, its' distribution in Finland is carried out via state-owned reselling monopoly Alko. Company's' main mission is to reduce alcohol related harms. Alko has the sole right to sell alcoholic beverages above 5,5 abv. for off-licence consumption, excluding few exceptions.

Alko has the following comments on the WHO action plan working paper about implementing the Global Strategy to Reduce the Harmful Use of Alcohol.

As the WHO states, worldwide alcohol consumption has not been decreasing during the last years. Between 2010 and 2018 the consumption has remained relatively stable at about 6 liters. The highest levels of consumption were detected in Europe. Some parts of Europe have been able to decrease the alcohol consumption of younger citizens, but in Finland it remains unclear if this trend will continue (Lintonen & Ahtinen & Konu). We highlight that there is plenty to be done with this changing attitude towards alcohol among younger generations and these covert tendencies should be capitalized in implementing the Global Strategy to Reduce the Harmful Use of Alcohol.

That being said, it is clear that the use of alcohol among citizens isn't homogenous. The COVID-19 has shown that the so-called K-trend may affect many areas of social life and is not merely a concept of economic life. At least Finland has seen that although the overall consumption of alcohol seem to have decreased by 10 percent during the first seven months of 2020, 8 percent of replicants taking part in a survey conducted by the Finnish Institute for Health and Welfare have increased their consumption of alcohol. Our concern is that the burden of alcohol related harms pile to the less fortunate citizens and we emphasize that it is very important to continue work against unfair division of harms.

Third, we would like to take this opportunity to underline the importance of research. The WHO has done tremendous work in bringing its' reports and analysis on reach of the decision makers and the public. We see that this work on articulating research should continue although lately the global tendency on many sectors of life has been to underestimate expertise and research.

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Lintonen, T., Ahtinen, S., & Konu, A. (2020). Alcoholic beverage preferences among teenagers in Finland before and after the 2018 alcohol law change. *Nordic Studies on Alcohol and Drugs*, 37(2), 141–152. <https://doi.org/10.1177/1455072520910547>

Attachment(s): 0

American Public Health Association

Department/Unit: *Alcohol, Tobacco, and Other Drugs Section*

Country/Location: United States of America

Submission

We respectfully submit comments in five areas where we see the opportunity to strengthen the document: 1) the SAFER Initiative, 2) Capacity, 3) Industry Involvement, 4) Trade Agreements, and 5) A Framework Convention on Alcohol Control. We provide more detail in each of these areas in the attached letter. The recommendations we make are to strengthen the language and emphasis of the working document, by strengthening the emphasis on the importance of pricing and taxation, including more specific recommendations for building capacity among nation-states and local governments to enact alcohol policies and implement strategies, explicitly identifying and controlling the inhibitive influence of the alcohol industry, including evidence-based alcohol policy in trade agreements, and calling for a Framework Convention on Alcohol Control. We applaud WHO for continuing to support and lead efforts to address the harmful consequences of alcohol consumption and related problems and look forward to continued partnership to reduce alcohol-related harms.

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00235_38_apha-atod-section-letter-on-who-action-plan-final-20201206.pdf



APHA Alcohol, Tobacco, and Other Drugs Section Response to WHO Working Document for Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Introduction

On behalf of the American Public Health Association’s Alcohol, Tobacco, and Other Drugs Section, we appreciate the opportunity to provide comments on the World Health Organization working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. We have reviewed the working document and are pleased at its comprehensive content. This will build on the 2010 WHO Global Strategy to Reduce Harmful use of Alcohol, which has been a valuable contribution to worldwide efforts to reduce alcohol consumption and related harms. We respectfully submit comments in five areas we see the opportunity for strengthening the document: 1) the SAFER Initiative, 2) Capacity, 3) Industry Involvement, 4) Trade Agreements, and 5) A Framework Convention on Alcohol Control. We provide more detail in each of these areas in the following pages.

SAFER Initiative

Overall, we applaud the emphasis on the SAFER initiative, as we agree it is the shortest path to achieve the ambitious targets laid out in the working action plan. The text in the first paragraph of the “Scope of the Action Plan” section references marketing as a chief concern. We agree that this focus on marketing is warranted. However, we would recommend also adding pricing and availability policies to this paragraph. Even though countries consistently reported making progress in pricing policies on the 2015 Global Questionnaire on Progress in Alcohol Policy,¹ the recent work on policy scoring in the Americas and the European Region shows that pricing is the action area in which countries have the lowest levels of implementation.^{2,3}

This is problematic for three reasons: 1) Pricing policies are the most effective policies at reducing consumption and related harms,^{4,5,6} 2) The revenues from taxation could be used to fund additional policy and intervention development, and 3) Pricing measures such as minimum unit pricing have strong potential to reduce inequalities.⁷ Although availability is the area with the highest level of implementation reported in the 2018 Global Survey on Alcohol and Health,^{2,3} it is also the action area in which countries were making the slowest progress.^{1,8} Further, with the COVID-19 pandemic, many governments are

loosening controls on the physical availability of alcohol by allowing internet sales, home delivery, and/or allowing on-premise establishments to function as if they were off-premise outlets.⁹ There is the possibility that governments may make these changes permanent after the pandemic subsides, particularly in countries facing economic hardship and looking for additional sources of revenue.

Capacity

We recommend strengthening the section on capacity-building and technical assistance, as this is essential to improved implementation of evidence-based, policy efforts; building capacity of public health professionals and practitioners and policymakers to support their efforts to implement effective program and policy.

There are limitations on the capacity to prevent alcohol-related harms and implementation of high impact interventions within high-income regions, but these are particularly problematic in low- and middle-income countries.¹⁰ The WHO working action plan could be substantially strengthened by providing additional, stronger and specific detail on what is meant by capacity enhancement and offer further guidance on components such as training, tools for implementation, regulations, and increased enforcement.

Investment in capacity building and enhanced technical assistance is critical for member states and the WHO Secretariat. This is necessary to adequately create, regulate, enforce, and sustain policies and mechanisms for implementation of interventions based on the best available science. These investments in capacity enhancement should be undertaken by member states in concert with the WHO Secretariat through dedicated and sustained leadership.

We support reconvening the WHO Expert Committee (Actions for the Secretariat #7) and suggest this meeting should precede the creation of additional training or the development of additional informational channels referred to in Actions #1, #3, or #5 within that section. The Expert Committee should play an integral role in the development of global efforts by the Secretariat to strengthen the international network of experts referenced in Action #4.

Of note, implementation within the context of local governance and customs is not a single accomplishment but an ongoing effort, creating a continuing need for capacity building to support these efforts.^{11,12,13} Although never defined, several references are made to creating and supporting the local “infrastructure” to support implementation of high impact interventions. If that infrastructure is to include legal and public policy experts, that should be explicitly stated. Further, law enforcement at the national or subnational levels is an essential part of that infrastructure and should be referenced in Action #2 and Action #4 for member states.

Additionally, for effective implementation and enforcement of high impact interventions to occur, specific tools and knowledge enhancements are needed by local communities within the member states. This could include, for example, detailed knowledge on country alcohol pricing and taxation policies, licensing of alcohol outlets, and type and density of outlets.¹⁴ Providing appropriate tools for civil society and public health professionals before an intervention is introduced has been shown to enhance its progress and impact. Doing so will ensure an adequate foundation within the community environment to better understand the local context, data, protocols, and regulations.

Finally, inviting those actively engaged in alcohol production and trade to increase their capacity in this field (Actions for Nonstate Partners, Action #3) condones the involvement of an inherently conflicted sector in both capacity building and implementation work. Experience and evidence both indicate industry involvement will undermine the critically needed implementation of high impact interventions and will confound efforts to reduce alcohol-related trauma, chronic disease, and social problems.

Industry Involvement

The WHO working action plan highlights that the role of all operators within the alcohol industry in the policy development and implementation process is minimal to non-existent. This is a positive aspect of the working document. However, we recommend using stronger language in the proposed action steps and elsewhere in the document to prevent the alcohol industry from exploiting ambiguous language as a means to insert itself in the policy process of member states, particularly within low- and middle-income countries. This includes:

- Identifying lobbying by commercial interests as the primary reason for the lack of implementation of alcohol control policies in member states (pgs. 3-4)
- Using the more precise term “non-economic stakeholders” instead of “relevant stakeholders” or “different stakeholders” (pgs. 6, 15, 16, and 19)
- Using the strongest possible language in the proposed actions for non-State actors that all economic operators within the alcohol industry should not be part of the policy process under any circumstances

These changes are needed for two reasons. First, economic operators in alcohol production and trade have a long history of advocating against the implementation of strong alcohol control measures. Economic operators are not, and should never be, considered as a part of the whole of society. These entities have lobbied against increases in alcohol price, whether through tax increases or other means;¹⁵ argued against decreasing the blood alcohol concentration limit for driving;¹⁶ have taken advantage of the COVID-19 pandemic to expand access to alcohol;⁹ have attempted to distort science to promote regular alcohol consumption;¹⁷ and have promoted self-regulation as the sole and most effective method for regulating alcohol marketing activities.¹⁸ These positions are not supported by scientific evidence and are contrary to public health goals. These considerations are not merely about a decision to involve a segment of the private sector; this is the alcohol industry, the very segment that has a vested commercial interest in the

sale and consumption of a harmful product. This should be a clear warning sign to us while their conflicted business practices should also give us serious pause.

For example, an assessment of alcohol industry initiatives concluded that 96.8% lacked scientific support, 26.5% had marketing potential for a specific brand, and 11.0% had the potential for harming the consumer.¹⁹ Further, in the United States, alcohol producers privately discussed the details, and ultimately funded through the National Institutes of Health, a study intended to prove that one alcoholic beverage a day had positive health effects.¹⁷ This occurred despite the lead investigator publicly denying any involvement by the industry; such conversations occurring before research funding was provided; and public acknowledgement that the study would not have been able to detect any harms associated with alcohol consumption, such as increases in breast cancer or heart failure.

Second, the strongest possible language against alcohol industry involvement is needed as a signal to member states that the alcohol industry should not be a participant in alcohol policy development and is not welcome in the process. Industry actors are known to be highly strategic and sophisticated in their lobbying efforts, and when involved, economic operators in the alcohol industry can effectively mitigate short- and long-term threats to economic interests while simultaneously excluding items from policy agendas that are contrary to commercial interests.²⁰

For these reasons, we strongly urge the WHO to adopt stronger and more precise language in its action plan for implementing the global strategies that makes it clear to member states, partners within the United Nations system, non-economic non-government organizations, and all economic operators involved in the alcohol industry that the alcohol industry must not be part of the alcohol policy process. We discourage inclusion of the very industry that fights evidence-based strategies in every corner of the globe to be invited as a valid partner in this important work.

Trade Agreements

Global trade produces economic benefits as well as harms. Over the last several decades, multilateral trade agreement negotiations have emerged that establish a new framework for global trade governance and a new model for future trade agreements with far-reaching implications for health and alcohol policy.

While alcohol is attributed to 4.0% of the global burden of disease, undercuts 14 of the 17 Sustainable Development Goals, and is a major risk factor for Non-Communicable Diseases (NCDs), recognition of prevention and treatment of NCDs as a global health priority has identified trade agreements as “upstream drivers” of these preventable diseases.^{21,22} Trade agreements are negotiated by nation states almost always with significant influence of commercial interests. Through both direct legal challenges and indirect regulatory “chill” effects, Investor State Dispute Settlements (ISDS) provisions, for example, can and have been used by industry to undermine many evidence-based

interventions, including tobacco, alcohol, and obesogenic product control efforts, designed to prevent and control NCDs. Moreover, trade agreements offer several additional potential avenues for industry to challenge or undermine alcohol control measures, including: trademark protections; stakeholder provisions that could expand industry influence on policy-making; cross-border service provisions that could limit restrictions on advertising and licensing; technical barriers to trade provisions, which could interfere with governments' ability to enact and implement alcohol control policies; and nondiscrimination requirements used to protect alcohol company products and practices. Failure to craft explicit and specific provisions that address each of these threats with certainty holds the potential to sabotage alcohol control efforts under the WHO Global Strategy to Reduce the Harmful Use of Alcohol and the SAFER Initiative.

To protect current and future alcohol control measures, we advocate for alcohol to be classified as an extra-ordinary commodity and that measures affecting the supply, distribution, sale, advertising, sponsorship, and promotion of or investment in alcoholic beverages be excluded from international trade agreements.

We recommend that the Secretariat should provide member states and civil society with technical resources to assure that alcohol control measures are not undercut in trade agreements. Trade agreements must not and should not impede, impair, or otherwise hinder governments' ability to enact and implement evidence-based policies to protect and improve public health. Ensure that trade agreements protect, promote, and prioritize public health over commercial interests, when such commercial interests may undermine or threaten public health, and seek to ameliorate rather than exacerbate global health disparities and inequities. Such capacity resources can protect evidence-based policies from being undermined by commercial interests. We urge transparency and openness in all trade agreement negotiations, including appropriate and timely public access to negotiating texts and meaningful and equitable opportunities for stakeholder engagement and feedback. Lastly, we urge the WHO to fulfill its mandate under resolution WHA59.26 on international trade and health to provide support to member states and collaborate with international organizations to ensure policy coherence on trade and health at the regional and global levels.

Framework Convention on Alcohol Control

The WHO working action plan would be strengthened by inclusion of support for a Framework Convention on Alcohol Control. The American Public Health Association has supported a Framework Convention on Alcohol since 2006.²³ Alcohol remains the only psychoactive and dependence-producing substance with a significant impact on global population health that is not controlled at the international level by legally binding regulatory instruments. The global alcohol epidemic is driven by trade liberalization, direct foreign investment, global, transnational, marketing (advertising, promotions and sponsorship) increasingly relying on use of technology, international tax schemes, and exploitation of cross-border trade.

A softer approach of two global strategies targeting alcohol-related harm has been tried. However, the WHO voluntary global NCD target for 2025 of a 10.0% reduction in harmful alcohol use is unachievable with current approaches.⁸ While the SAFER Initiative is an important contribution, its impact will be limited without a stronger global commitment. Moreover, national and subnational governments find it difficult to regulate the distribution, sale and marketing of alcohol within the context of international, regional, and bilateral trade negotiations, as well as to protect the development of alcohol policies from interference by transnational corporations and commercial interests – problems that transcend national boundaries. Alcohol problems have proven difficult or impossible to mitigate by countries acting in isolation.

While an alcohol control convention could seek international action on trade and cross broader problems, the principal effect would likely be at the national and sub-national level by setting new norms and practices of alcohol control. Based on experience of the Framework Convention on Tobacco Control (FCTC), in addition to specific obligations and principles within a framework convention, the process of negotiating the treaty would strengthen alcohol control efforts within countries by giving governments greater access to scientific research and examples of best practice and motivating national leaders to rethink priorities as they respond to an ongoing international process. This would engage powerful ministries, such as finance and foreign affairs along with health ministries, more deeply in alcohol control and raise public awareness about the strategies and tactics employed by the multinational alcohol companies.

The international collaboration would mobilize technical and financial support for alcohol control at both national and international levels and make it politically easier for developing countries to resist the alcohol industry opposition to effective measures, for example, raising taxes and restrictions on advertising. The convention will help mobilize civil society in support of stronger alcohol control. Moreover, it will create a sense of obligation in Member States that are acting in good faith and wish to comply with their treaty commitments and also deter violations. Even without enforcement mechanisms, an alcohol treaty can bring about positive changes in how Member States, and ultimately individuals, behave.

The time has come for a global, binding treaty on alcohol control. Such an instrument is clearly the best and most ambitious way forward to tackle the host of challenges, shortcomings and problems of the WHO Global Strategy to Reduce the Harmful Use of Alcohol as well as help protect the human right to health and development; ensure the achievement of global and national targets for reduction of alcohol use and related harm; and curb alcohol industry interference.

Conclusion

In summary, we believe the WHO working action plan makes important improvements for continuing progress toward the goals of the 2010 Global Strategy to Reduce the

Harmful Use of Alcohol. The recommendations we submit in this document strengthen the language and emphasis of the working document, by strengthening the emphasis on the importance of pricing and taxation, including more specific recommendations for building capacity among nation-states and local governments to enact alcohol policies and implement strategies, explicitly identifying and controlling the inhibitive influence of the alcohol industry, including evidence-based alcohol policy in trade agreements, and calling for a Framework Convention on Alcohol Control. We applaud WHO for continuing to support and lead efforts to address the harmful consequences of alcohol consumption and related problems and look forward to continued partnership to reduce alcohol-related harms.

Sincerely,



Paul A. Gilbert, PhD
Chair, Alcohol, Tobacco, and Other Drugs Section
American Public Health Association

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Anti Drug Abuse Association of Lesotho (ADAAL)

Country/Location: Lesotho

Submission

SUGGESTIONS FOR CONSIDERATION

ADAAL is disappointed that the document have increased the role of the economic actors and afforded them equal status. ADAAL believes that the current bi-annual consultations with industry in not in the interest of public health, and is used by the industry to influence their profit driven strategies.

ADAAL strongly recommend that the role of the economic actors is not as explicitly detailed for every action area. The industry should not have a role in the implementation of the global strategy.

ADAAL proposes that the role of the economic actors is contained to a separate paragraph with limited role and that reference under each action area is removed.

Whilst acknowledging that the document contains recommendations with regards to conflict of interest, ADAAL proposes that the issue of COI is fore-fronted more.

The general language of the action areas is not strong enough

ADAAL recommends that the list of actions is reduced and focused on the WHO 'best buys' and SAFER strategy.

Action Area 1

1. Reference to COI should be made.
2. Member states should be supported to adopt a COI policy.
3. WHO Secretariat discontinue dialogues with industry.

Action Area 2

1. A COI policy should be included as a target.
2. Member states should be supported to establish Health promotion Foundations (HPFs) similar to Thai Health.
3. CSI funds should be directed to HPFs to ensure that evidence-based interventions are funded, not skew resources to industry promoted alcohol interventions and reduce the marketing opportunity CSI for the industry.
4. Member states supported to establish independent statutory advertising monitoring mechanisms.
5. WHO Secretariat revisit standard drink vs container sizes recommendations to member states. Industry currently marketing 1l beer bottles. Container sizes are often misinterpreted by consumers as standard unit sizes.

6. Member states be given timelines for adoption of policies in line with the strategy.

Attachment(s): 1

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Submission - WHO Consultation - Working Document to develop an action plan for improving WHO GAS* implementation

Anti Drug Abuse Association of Lesotho (ADAAL) is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

ADAAL is a civil society organization that works to reduce the alcohol and drugs related harm in Lesotho. It focuses on Prevention, Advocacy for evidence based and public health focused alcohol policy.

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

- A. 7 Points for Action Plan Improvement
 1. Ensure bold targets and ambition
 2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
 3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
 4. Ensure greater focus on the SAFER strategies;
 5. Ensure greater focus on governance and infrastructure improvements;
 6. Improve resourcing as well as reporting and review of implementation; and
 7. Update nomenclature in line with state-of-the-art evidence.
- B. Additional point to be added to the action plan
 1. Suggestion for elements of the action plan
- C. Point of criticism and request for significant change
 1. Role of the alcohol industry, conflict of interest

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome - and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR

4. Lack of political will and leadership at highest levels
5. Policy incoherence

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as "complex" problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. "Complexity" arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change "the old" way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty - also to underpin the inclusion of "multisectoral action" as operating principle in the action plan.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world's children. The WHO-UNICEF-Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children's health, well-being and development - one of those being counter action against "predatory corporate behavior", including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets - the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions. Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

Where possible, actions and key indicators should be time-bound.

4. Ensuring greater focus on the SAFER strategies

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan to ensure

that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions - to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol. We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys - that has largely fallen short of necessity - is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document. Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements - learning lessons from other health areas.

Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions - like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO - like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention - like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) - like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm - like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm - like it was recently launched for AMR.

7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings - like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals - like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO's expert groups/ committees on alcohol - like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol - despite the existence of SDG 3.5 - to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

Regarding the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called "Infrastructure".

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential - as tobacco

control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden. For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level. We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through "SAFER pilot countries".

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial - both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that

alcohol corporations and their lobby groups have in increasing the sale of alcohol.

B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets
2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.
3. Framework for action
 - Operational objectives: 8
 - Priority areas for global action: 6
 - Global action: WHO
 - National action: Member States
4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the

global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

APN (Alcohol Policy Network in Europe)

Country/Location: Austria

URL:

https://drogues.gencat.cat/ca/professionals/projectes_internacionals/apn_alcohol_policy_network_in_europe/apn-website

Submission

APN comments are in the attached file

They are also pasted in below:

Alcohol Policy Network in Europe (APN)

Comments on WHO Global Strategy Plan (December 2020)

0) APN was very pleased with the EB decision signaling an increasing interest in WHO and its governing bodies to give more priority to addressing the harmful use of alcohol. This combines well with APN's principal objective 'to provide and promote support for implementing healthy alcohol policies at community, national and international European level'. The current consultation is much appreciated and is a great opportunity to raise awareness and gain wide endorsement for prioritizing public health oriented alcohol action at all levels. APN will be keen to contribute and cooperate in this WHO led movement.

1) We find the introductory texts and background information excellent. However, we were wondering why the plan itself doesn't consistently follow up on the issues addressed in the introductory pages.

1a) The most striking and important example here is the absence of any reference in the plan itself to international binding regulations to control the harmful use of alcohol. While this is mentioned several times as an important issue in the introductory pages, the plan itself does not spend a single word on it; it occurs to us that the plan itself could at least include for example a feasibility exercise and give attention to principal goals and medium and longer term outcomes.

1b) In this connection it is also worth mentioning that the plan seems to take for granted that communications or dialogue between WHO and the economic operators are to be continued. To us this is not self evident. Including this 'dialogue' in a WHO action plan is further likely to be perceived by many national and sub-national governments as the right thing to do – whereas there is hardly any evidence to support this. We can anticipate that it will continue to be used by parties that have no principle interest in public health to gain access to policy making. Here it is relevant also to keep in mind the principle that a public health policy is to be developed and determined by public health interests and their entities (in slightly different words rightly mentioned as the principle nr 1 in Box 5 on p 10). APN has been giving much attention to this subject over the past years; resulting in a document providing guidance on the role of the industry in alcohol policy making (which is accessible on its website).

1c) In this connection we further wonder if more emphasis could be given to the issue of cross border alcohol marketing, advertising and promotional activities (there is even no reference to this important issue in the Annex 1) - as the EB decision itself rightly identifies this as an action point! The importance of this issue doesn't need much elaboration: without any relevant international regulation, the individual country or community is powerless to implement control on cross border marketing.

2) The structure and the language of the document as from p 7 are complicated.

The language used is often unclear and not concrete (as examples of the latter: see the first sentence under Action area 3 – p 15; the text in Action 4 for MS under Action Area 2 – p 13; the text in Action 3 for WHO in Action Area 2 – these are just examples, in our opinion this is a general issue that needs to be addressed in the revision).

Re the structure we wonder if the whole plan could not simply be structured along the Objectives of the Global Strategy - with one 'concluding' additional Objective on the SAFER actions. This would bring more consistency and clarity in the argumentation.

2a) More particularly, we find the logical building up from the Objectives of the Global Strategy with its Key Components of the Global Action and its Recommended Target Areas, through the Operational Objectives, the Operational Principles for Global Action to the Key Areas for Global Action – with a short excursion to the Guiding Principles of the Global Strategy - (from mid p 7 till end p 10) rather confusing. If there are good reasons to deviate from the objectives of the Global Strategy it may be good to mention these specifically. It occurs to us that the Key Components of the Global Strategy basically encompass all the elements mentioned under the 6 Key Areas for Global Action - except for the Implementation of High Impact Strategies (key area nr 1).

2b) At the end of p 9 for example a number of principles and approaches are presented for consideration as complementary to the guiding principles in the global strategy. They are all interesting – but nothing is being done with them further on. So they may just as well be deleted?

2c) We feel that, if the current 6 Key Areas are to be maintained, a different sequence would be more logical: a) knowledge production and dissemination; b) awareness, advocacy and commitment; c) technical support and information; d) partnerships and coordination; e) resource mobilization; f) implementation of high impact strategies.

2d) The 'best buys' plus drink-driving measures are widely accepted and regarded to be among the most effective policy actions. As these are the main priorities, we wonder if these could not be mentioned explicitly in the Annex 1 as indicators.

3) The text for Action Area 2 includes the idea of an 'international day of awareness' (which may be also a week or a month?). In the Actions itself this leads to "national awareness" action, but not to specific international action for the Secretariat?

3a) The text introducing Action Area 2 should contain a reference to labeling, perhaps immediately following the preceding issue – which correctly is included as Action nr 7 in the proposed action for MS and Action nr 6 for Secretariat. Further it would be helpful to have here a reference to warning signs (pregnancy, certain medications etcetera).

4) It occurs to us that Action Area 4 might well pay more attention to the role of the health and social welfare sector. In particular the role of primary health care is critical for prevention, early diagnosis and brief interventions and deserves to be mentioned as such.

5) There are correctly many references to partnerships and the need for collaboration; in this connection it might be useful to name some of the most important and natural partners: the national medical associations and national institutes for public health. As we know from experiences, they can play a critically important role in knowledge transfer and advocacy for public health oriented alcohol policies.

6) The plan repeatedly refers correctly to the relevance of special efforts needed in LMIC; it occurs to us that the WHO Country Offices could and should play an important role here. Could / should their contribution explicitly be mentioned?

7) It occurs to us that references to Covid-19 in this document are not absolutely necessary - as long as there are sufficient references to the influence of alcohol consumption on CD's and NCD's.

APN will be pleased to clarify further these comments, if needed. APN will also be happy to cooperate with WHO to further develop and implement global action to reduce the harmful use of alcohol.

Attachment(s): 1

00384_40_apn-comments-who-global-stategy-plan.pdf

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APN will be pleased to clarify further these comments, if needed. APN will also be happy to cooperate with WHO to further develop and implement global action to reduce the harmful use of alcohol.

Asia Pacific Alcohol Policy Alliance

Country/Location: Singapore

URL: Twitter @AsiaPacAPA

Submission

The Asia Pacific Alcohol Policy Alliance (APAPA) lauds the tremendous effort to prepare the working document. APAPA supports setting specific, measurable, achievable, relevant, and time-bound global targets for all the six action areas. As a regional alliance under the Global Alcohol Policy Alliance (GAPA), APAPA also adopts the position of GAPA (attached) on the working document.

APAPA supports the working document's perspectives on the needs of low- and middle-income countries in tackling harmful alcohol use. This is especially relevant to the Asia Pacific. According to the Global Burden of Disease Study 2019, alcohol use is the top risk factor among people aged 15-49 years in low-and middle-income countries including Cambodia, Kazakhstan, Kyrgyzstan, Lao PDR, Mongolia, Myanmar, the Philippines, Sri Lanka, Taiwan, Tajikistan, Thailand, Turkmenistan and Vietnam, and even in high-income countries including New Zealand and South Korea (IHME 2020). Alcohol policy needs to be prioritized in these countries and the action plan needs to sufficiently consider the needs of the Asia Pacific region to tackle harmful alcohol use.

APAPA, along with GAPA, would like to highlight that it does not support that the structure of the action statements includes a role for economic operators as if they are equivalent to other non-state actors. It leads to 'invitations' to economic operators which does not take into account their primary commercial responsibilities to shareholders and the reliance for substantial sales on heavy drinking occasions and individuals with alcohol use disorders, and as if their role as alcohol producers do not pose a conflict of interest for public health and the overall agenda of the Global Strategy to reduce harmful use of alcohol.

For the full submission, please see attached.

Attachment(s): 2

00334_14_apapa-submission-to-who-2020.pdf

00334_13_gapa-submission-to-who-consultation-11-dec-2020.pdf

Asia Pacific Alcohol Policy Alliance

Position Paper on the WHO Working Document on the Global Action Plan

We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration:

1. The Asia Pacific Alcohol Policy Alliance (APAPA) lauds the tremendous effort to prepare the consultation document.
2. APAPA supports setting specific, measurable, achievable, relevant, and time-bound global targets for all the six action areas.
3. As a regional alliance under the Global Alcohol Policy Alliance (GAPA), APAPA also adopts the position of GAPA on the working document.
4. APAPA supports the working document's perspectives on the needs of low- and middle-income countries in tackling harmful alcohol use. This is especially relevant to the Asia Pacific. **According to the Global Burden of Disease Study 2019, alcohol use is the top risk factor among people aged 15-49 years in low-and middle-income countries including Cambodia, Kazakhstan, Kyrgyzstan, Lao PDR, Mongolia, Myanmar, the Philippines, Sri Lanka, Taiwan, Tajikistan, Thailand, Turkmenistan and Vietnam, and even in high-income countries including New Zealand and South Korea (IHME 2020).** Alcohol policy needs to be prioritized in these countries and the action plan needs to sufficiently consider the needs of the Asia Pacific region to tackle harmful alcohol use.
5. APAPA, along with GAPA, would like to highlight that **it does not support that the structure of the action statements includes a role for economic operators as if they are equivalent to other non-state actors.** It leads to 'invitations' to economic operators which does not take into account their primary commercial responsibilities to shareholders and the reliance for substantial sales on heavy drinking occasions and individuals with alcohol use disorders, and as if their role as alcohol producers do not pose a conflict of interest for public health and the overall agenda of the Global Strategy to reduce harmful use of alcohol.

ON THE GLOBAL TARGETS

6. APAPA recommends that the SAFER Initiative be specified in Global Targets 1.1 and 1.3 to serve as a strong and clear policy target for member-states to

implement the SAFER package of policies and interventions. While SAFER is specified in the proposed actions, identifying SAFER in the target itself offers a less ambiguous target for policy. A focus on low- and middle-income countries should also be specified in the target given the expansion of the alcohol industry's activities in these countries especially in the Asia Pacific.

[Note: All underlined are suggested additions to the targets.]

Proposed:

- *Global target 1.1. By 2030, 75% of low- and middle-income countries have introduced and/or strengthened and sustainably enforced implementation of the high-impact policy options and interventions under the SAFER Initiative.*
- *Global target 1.3. By 2030, 80% of the world's population are protected from the harmful use of alcohol by sustained implementation and enforcement of high impact policy options under the SAFER Initiative with due consideration of national contexts, priorities and available resources.*

7. APAPA recommends that a target to reduce alcohol per capita consumption among young people aged below 15 years old should be considered. WHO data shows that a worrying 15–30% of young people drink alcohol in the Western Pacific region alone, where the majority of the global population resides.

Proposed:

- *Global target 1.2.[b] By 2030, at least a [x]% relative reduction in alcohol per capita consumption (among those aged below 15 years old) by 2025 and a [x] relative reduction by 2030.*

8. APAPA suggests that the global targets under Action Area 3, 4 and 6 also be time-bound, measurable and **specify** the measures under the SAFER initiative as priority alcohol control measures, where applicable:

Proposed:

- *Global target 3.1. By 2030, [x]% of countries have established and functioning national and subnational multisectoral coordination mechanisms for implementation and strengthening of effective alcohol control measures, including the measures under the SAFER initiative.*
- *Global target 3.2. By 2030, 75% of countries are engaged in and contribute to the work of the global and regional networks of WHO*

national counterparts for international dialogue and coordination on reducing the harmful use of alcohol.

- *Global target 4.1. By 2030, 50% of countries have increased capacity and infrastructure for implementation of high-impact strategies and interventions to reduce the harmful use of alcohol, including SAFER measures.*
- *Global target 4.2. By 2030, 50% of countries have increased capacity to provide prevention and treatment interventions for health conditions due to alcohol use in line with the principles of universal health coverage.*
- *Global target 6.1. By 2030, 50% of countries have increased available resources for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.*
- *Global target 6.2. By 2030, at least 50% increase in the number of countries with earmarked funding from alcohol tax revenues for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.*

ON THE PROPOSED ACTIONS

Action Area 1. Implementation of high-impact strategies and interventions

- **Proposed Actions for the WHO Secretariat**
 - **On Action 4.** APAPA suggests that all dialogues with economic operators in the area of alcoholic beverage production and trade be transparent, and proceedings publicly available.

Action Area 2. Advocacy, Awareness and Commitment

- **Proposed Actions for Member States**
 - **On Action 5.** APAPA supports regular national reports on alcohol consumption and alcohol-related harm, and acknowledges that regular reporting will support the dissemination of the WHO Global Status Reports on Alcohol and Health. APAPA suggests that this reporting be every 2 years.

- **On Action 6.** APAPA, along with Global Alcohol Policy Alliance (GAPA), supports the proposal for member states to increase awareness of the health risks of alcohol use and related overall impact on health and well-being. The option to implement a national alcohol awareness day, however, is not sufficient given the range of harms to health and society that alcohol causes and should be replaced with an option of a national alcohol awareness week. APAPA considers that if there can be month-long alcohol-themed festivals as part of the marketing strategy of alcohol companies to boost alcohol consumption, then a national alcohol awareness month by public health agencies and civil society organisations should also be considered.
- **Proposed Actions for the WHO Secretariat**
 - **On Action 4.** APAPA notes that Global Status Reports on Alcohol and Health were proposed to be prepared every 4-5 years. We note that the tobacco status reports required under the Framework Convention on Tobacco Control are released every 2 years. We suggest that the Action Plan emphasize that the WHO Secretariat be given adequate resources to be able to prepare and disseminate the global status reports every two years.

Proposed Action 4. *Prepare and disseminate every 2 years global status reports on alcohol and health to raise awareness of the alcohol-attributable burden and advocate for appropriate action at all levels.*

Proposed Actions for Non-State Actors

- **On Action 3.** If actions for economic operators remain in the Action Plan, APAPA supports the elimination of marketing and advertising of alcoholic products to minors, and additionally, elimination of promoting drinking, elimination and prevention of positive health claims for alcohol, however APAPA suggests that legally-binding regulatory frameworks replace the proposed “co-regulatory framework” to avoid ineffective voluntary regulatory mechanisms or self-regulation by the economic operators.

Proposed Action 3: *Economic operators in alcohol production and trade as well as operators in other relevant sectors of the economy are invited to take concrete steps, where relevant, towards eliminating the marketing and advertising of alcoholic products to minors, eliminate promoting drinking, eliminate and prevent any positive health claims, and ensure, within legally-binding regulatory frameworks, the availability of easily-understood consumer information on the labels of alcoholic beverages (including composition, age limits, health warning and contraindications for alcohol use).*

Action Area 3. Partnership, Dialogue and Coordination

Proposed Actions for the WHO Secretariat.

- **On Action 6.** APAPA suggests that dialogues with economic operators in alcohol products and trade be limited as much as possible and only be conducted when necessary with transparency mechanisms (all proceedings to be made publicly available) in place to reduce avenues for industry interference. APAPA notes that the proposed annual dialogue is more regular than the proposed Global Status Reports on Alcohol and Health to be released every 4 to 5 years.

Proposed Action 6. *Organize global dialogues with economic operators in alcohol production and trade only when necessary, with appropriate and adequate transparency mechanisms to be put in place.*

Proposed Actions for Non-State Actors.

- **On Action 3.** APAPA, along with the Global Alcohol Policy Alliance (GAPA), supports this statement asking for economic operators to refrain from policy interference. However, we propose that it be addressed in a separate section and should be rewritten to:

Proposed Action 3. *Economic operators in alcohol production and trade are invited to focus on their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages, and abstain from engaging in and/or interfering with alcohol policy development and evaluation.*

Action Area 6. Resource Mobilization

● Proposed Actions for Non-State Actors

- **On Action 1.** APAPA, along with GAPA, supports the focus on Resource Mobilisation and applauds invitation to UN agencies to maintain independence from funding from alcohol producers and distributors. Given that transnational alcohol corporations have contributed funding to UN agencies through their corporate social responsibility initiatives, this needs to be highlighted.

Proposed Action 1. *Major partners within the United Nations system and intergovernmental organizations are invited to mainstream and integrate their efforts to reduce the harmful use of alcohol in their developmental and public health strategies and action plans and to promote and support financing policies and interventions to ensure the availability of adequate resources for accelerated implementation of*

the Global Strategy while maintaining independence from funding from alcohol producers and distributors.

About the Asia Pacific Alcohol Policy Alliance

The Asia Pacific Alcohol Policy Alliance (APAPA) serves as a collaborative & learning space on alcohol policy developments for its members and a network of non-government organizations and individuals committed to the development of effective alcohol policy in the region to reduce alcohol-related harm worldwide by promoting science-based policies independent of commercial interests.

Twitter: @AsiaPacAPA

Members:

- National Alliance for Action on Alcohol (Australia)
- Foundation for Alcohol Research and Education (Australia)
- Cook Islands Road Safety (Cook Islands)
- Rural Development Tuki Association (Nepal)
- Cancer Society of New Zealand (New Zealand)
- Alcohol Action NZ (New Zealand)
- Rahama (Sri Lanka)
- Centre for Economics and Community Development (Vietnam)

Asociación Prolicores

Country/Location: Colombia

Submission

1. Reconocer el listado completo de opciones de política pública en torno a la reducción del uso nocivo de alcohol que sí estaba contemplado en la Estrategia Global aprobada en 2010.
2. No hacer uso indistinto del lenguaje. El enfoque debe estar en la reducción del consumo nocivo de alcohol y no en el consumo per se.
3. Incluir a los operadores económicos dentro de la discusión como parte de la sociedad y no desconocer el trabajo, el esfuerzo y el aporte que están haciendo para mitigar el consumo problemático de bebidas alcohólicas.

Attachment(s): 1

00360_29_concepto-relacionado-con-la-estrategia-mundial-para-reducir-el-uso-nocivo-del-alcohol-oms.pdf

Concepto relacionado con la estrategia mundial para reducir el uso nocivo del alcohol de la Organización Mundial de la Salud.

ANTECEDENTES NORMATIVOS

- 1.1. En el año 2010, en la Asamblea Mundial de la Salud No. 63, la OMS aprobó una estrategia mundial contra el consumo nocivo de alcohol, estableciendo una acción estratégica para reducir el uso nocivo del alcohol y mejorar la salud y el bienestar social, así como aliviar la carga de morbilidad atribuible al alcohol¹.
- 1.2. Desde la aprobación de la estrategia mundial en el año 2010, ha existido un mayor compromiso por reducir el uso nocivo del alcohol, aunado a las declaraciones de la Asamblea General de las Naciones Unidas sobre enfermedades no transmisibles (“ENT”) y en Plan de Acción Mundial de la OMS para la prevención y control de las ENT.
- 1.3. El 7 de febrero de 2020, el Consejo Ejecutivo de la OMS solicitó el desarrollo de un plan de acción (2022-2030) para implementar la estrategia mundial como una prioridad de salud pública, con el objetivo de *“brindar orientación para la acción a todos los niveles y establecer áreas prioritarias para la acción mundial”,* así como *“proporcionar un portafolio de opciones y medidas políticas que podrían considerarse para su implementación a nivel nacional a discreción de cada Estado Miembro, dependiendo de los contextos, prioridades y recursos nacionales”*².

El borrador del plan de acción que busca fortalecer la implementación de la Estrategia Mundial para Reducir el Uso Nocivo del Alcohol se aleja de la Estrategia Mundial para reducir el consumo problemático de alcohol, aprobada en 2010 y lo demostraremos con las recomendaciones que proponemos a continuación:

1. **Reconocer el listado completo de opciones de política pública en torno a la reducción del uso nocivo de alcohol que sí estaba contemplado en la Estrategia Global aprobada en 2010.**

Después de que la OMS, hace más de 50 años, considerara que la dependencia causada por el alcohol es un asunto de salud pública, mucho se ha avanzado en entender y prevenir el consumo excesivo de bebidas alcohólicas. En 2010, con la formulación y posterior aprobación de la Estrategia Mundial para Reducir el Uso Nocivo de Alcohol (EMRUNA), la OMS reconoció la necesidad de plantear soluciones integrales y eficaces frente al consumo problemático de bebidas alcohólicas.

Bajo ese marco, la OMS estableció un conjunto de políticas e intervenciones que los países miembros debían tener en cuenta a la hora de definir las “políticas sobre alcohol” que, a fin de cuentas, serían las encargadas de minimizar los daños sociales y de salud asociados al consumo de bebidas alcohólicas. La estrategia, promulgada con carácter mandatorio, dejaba, sin embargo, la decisión sobre el criterio de intervención a juicio de cada país.

¹ Disponible en:

https://apps.who.int/iris/bitstream/handle/10665/44486/9789243599939_spa.pdf;jsessionid=E8CDDFF30C41B8AAD96AE7C34B7C9F6E0?sequence=1

² CONSEJO EJECUTIVO EB146 (14) 146. ^a reunión 7. Disponible en: [https://apps.who.int/gb/ebwha/pdf_files/EB146/B146\(14\)-sp.pdf](https://apps.who.int/gb/ebwha/pdf_files/EB146/B146(14)-sp.pdf)

Así, se abrían dos líneas de política pública. La primera, actuar sobre el consumo propiamente dicho a través de una fuerte regulación. Es decir, ejercer control más directo sobre todas las instancias implicadas en el consumo de bebidas alcohólicas: impuestos, controles de precios, restricciones de expendio (edades mínimas de compra o suspensión del mercado en fechas específicas) y publicidad. La segunda, más disruptiva, actuar sobre los factores de riesgo del consumo problemático de alcohol. En este caso, se partía del reconocimiento de que hay un consumo que se considera nocivo y que, en esa medida, se puede prevenir y mitigar su impacto si se realiza un esfuerzo conjunto entre los gestores de política pública, la industria y la sociedad civil. La recomendación era pensar en estos enfoques como complementarios.

Las opciones de política y las intervenciones aplicables a nivel nacional se agruparon en 10 esferas de acción recomendadas, que, insistimos, se apoyaban y complementaban entre sí:

- I. Liderazgo, concienciación y compromiso
- II. Respuesta de los servicios de salud
- III. Acción comunitaria
- IV. Políticas y medidas contra la conducción bajo los efectos del alcohol
- V. Disponibilidad de alcohol
- VI. Marketing de las bebidas alcohólicas
- VII. Políticas de precios
- VIII. Mitigación de las consecuencias negativas del consumo de alcohol y la intoxicación
- IX. ética
- X. Reducción del impacto en la salud pública del alcohol ilícito y el alcohol de
- XI. producción informal
- XII. Seguimiento y vigilancia

Dicho eso, este nuevo borrador pone a la estrategia SAFER en el centro de las intervenciones mundiales y nacionales sobre el alcohol. El documento da a entender que el progreso global logrado en la reducción del uso nocivo de alcohol ha sido limitado, hasta ahora, por una implementación insuficiente de las políticas e intervenciones más efectivas y costo-efectivas sobre el alcohol. Es decir, da prioridad absoluta a aumentos de impuestos, prohibiciones de comercialización o restricciones de ventas y prácticamente no tiene en cuenta otras opciones de política que sí estaban incluidas en la Estrategia mundial que, además, ya había sido aprobada por los Estados miembro.

El borrador insiste en que el esfuerzo de los países se debe centrar en rastrear el progreso en la implementación de la iniciativa SAFER y no reconoce como válido el avance en la implementación de cualquier otra política identificada en la EMRUNA. Un hecho paradójico si se tiene en cuenta que el objetivo principal del plan de acción es “impulsar la implementación efectiva de la Estrategia Mundial como una prioridad de salud pública y reducir considerablemente la morbilidad y la mortalidad debidas al uso del alcohol, por encima de las estrategias generales de morbilidad y mortalidad, así como las consecuencias sociales asociadas”.

El documento menciona de forma ligera algunos de los importantes progresos de la EMRUNA. Por ejemplo, que el consumo de alcohol entre los jóvenes ha disminuido en muchos países de Europa, o que “la prevalencia estandarizada por edad de consumo excesivo de alcohol (definido como 60 o más gramos de alcohol puro en al menos una ocasión, al menos una vez al mes) disminuyó globalmente del 20,6% en 2010 al 18,5% en 2016”. Esa excesiva minimización de los avances se da, a nuestro juicio, para imponer la necesidad de implementar las llamadas medidas e intervenciones de alto impacto. Sobre ese aspecto,

consideramos que no hay que remplazar la Estrategia Mundial (que además firmaron los Estados miembro), hay que reconocer sus progresos y potenciarlos.

Por otra parte, hay que decir que la prohibición tiene efectos colaterales profundamente peligrosos en países de ingresos medios y bajos, como es el caso de Colombia. Euromonitor International lanzó un estudio donde ha demostrado que las prohibiciones de acceso a canales formales de venta, que se han implementado durante la emergencia generada por el Covid-19, se han traducido en un crecimiento del negocio ilícito de bebidas alcohólicas. El comercio ilícito aumentó un 9,7 % en América Latina durante la pandemia y se calcula que, al cierre del 2020, se habrán comercializado 750 millones de botellas de un litro por fuera de la legislación de cada país. Colombia es el país con mayor porcentaje de crecimiento de actividad ilícita con un 10,6 % más comparado con los niveles de 2019.

2. No hacer uso indistinto del lenguaje. El enfoque debe estar en la reducción del consumo nocivo de alcohol y no en el consumo per se.

No hay que perder de vista que la estrategia debe estar centrada en la reducción del consumo nocivo o problemático de alcohol y no dar mensajes indistintos con relación al consumo por sí mismo. El enfoque debe estar siempre dirigido a identificar los hábitos de consumo que se pueden tornar problemáticos y actuar sobre ellos. Esa era la directriz de la Estrategia Global y así debe permanecer.

3. Incluir a los operadores económicos dentro de la discusión como parte de la sociedad y no desconocer el trabajo, el esfuerzo y el aporte que están haciendo para mitigar el consumo problemático de bebidas alcohólicas.

El documento desconoce el rol activo que podrían tener los operadores económicos en la prevención del uso nocivo de alcohol y, de hecho, en varias ocasiones se refiere a ellos como una barrera para una implementación exitosa de estrategias de reducción del consumo. En varios pasajes se argumenta que los operadores no pueden ser parte de la discusión, como otro punto de vista de la sociedad, puesto que tienen intereses comerciales que sobrepasan al problema de salud pública de un país. El papel de los operadores, según el borrador, se limitaría a mantener diálogos con la secretaría de la OMS una vez cada año o incluso cada dos, ni siquiera se habla de un vínculo directo entre industria y entidades gubernamentales.

Una política integral no puede desconocer los esfuerzos que han adelantado algunos productores y distribuidores en relación a la reducción del consumo nocivo de alcohol, sobre todo, en lo que se refiere al mercadeo digital. Además, esos esfuerzos constituyen iniciativas de autorregulación por parte de la industria y hay que recordar que la EMRUNA incentivaba esquemas complementarios entre regulación y autorregulación, e insistía en que una política integral debía tener en cuenta a todos los actores que hacen parte del sector.

La industria es consciente de la problemática que encierra al consumo nocivo de bebidas alcohólicas, reconoce las externalidades que produce este tipo de ingesta y por eso admite que una política de uso responsable debe desarrollarse con base en la información. En torno al consumo nocivo de alcohol, que encierra diversos determinantes y efectos, la disponibilidad de información es aún limitada. Superar esa limitante es crucial en la formulación de una política coherente y con efectos reales y medibles de consumo responsable. Se necesita información para caracterizar los patrones de consumo, no solo desde la experiencia objetiva del individuo sino desde la subjetiva. Eso significa profundizar en las variables que determinan la condición socioeconómica de la población (ingreso, salud mental y física, nivel educativo,



PROLICORES

percepción de pobreza) y hacer un esfuerzo por formar una imagen completa del entorno en el cual el individuo se desarrolla y vive. Indagar, en último término, por las motivaciones, justificaciones, experiencias y realidades que “incentivan” u “originan” el consumo problemático o nocivo de bebidas alcohólicas.

Con conciencia plena del reto que eso supone, hay algunas iniciativas, impulsadas por la industria, en países de Latinoamérica que han hecho un esfuerzo por caracterizar los distintos tipos de consumo, desde el problemático hasta el de alta prevalencia que no representa conductas nocivas. Es el caso de algunas empresas que comercializan bebidas con contenido alcohólico que adelantan una investigación, en alianza con ANIF (Centro de estudios económicos), que buscan dar al Gobierno colombiano nuevas herramientas para que las políticas de consumo de alcohol no se limiten a prohibiciones discrecionales. El estudio ha avanzado en demostrar, mediante un análisis estadístico y econométrico, que la vulnerabilidad al consumo problemático se construye a través (y no a causa de) ciertas condiciones de carácter socioeconómico. Es decir que el consumo de alcohol problemático se puede prevenir si se identifican y caracterizan con mayor detalle a las poblaciones potencialmente vulnerables al consumo nocivo por medio de las variables que cada región o país encuentren relevantes.

A partir del estudio, la industria planea comprometerse a dos cosas fundamentales. Por un lado, a aportar información de calidad sobre hábitos de consumo que sirva al gobierno para hacer seguimiento a los índices de consumo de alcohol. Por el otro, espera que los resultados que arroje la investigación sean un insumo para establecer un estricto código de autorregulación que “proteja” del mercadeo, la disponibilidad y la venta a las poblaciones potencialmente vulnerables de un consumo que se pueda tornar problemático.

AssoBirra

Country/Location: Italy

URL: www.assobirra.it

Submission

- In the European Union, not only did alcohol consumption decline but so have key harm indicators such as heavy episodic drinking, drink driving accidents and fatalities. The recently published 2019 ESPAD report, building on the previous report and the HBSC reports, also show significant declines in both underage drinking and adolescent binge drinking.
- All these declines have actually taken place within a context where beer consumption has increased by 4% between 2010 and 2018.
- These data demonstrate how increased consumption of low alcohol beverages such as beer, in sectors such as brewing where there is also a growth in lower and non-alcohol versions, can actually result in improved health outcomes, as consumers switch from higher alcohol products.

Attachment(s): 0

Association des Guides du Rwanda

Country/Location: Rwanda

URL: www.rwandagirlguides.org

Submission

Our submission highlights 7 points for action plan improvement, provides additional point to be added to the action plan and raises points of criticism and request for significant change.

Detailed submission is attached.

Attachment(s): 1

00451_80_agr-who-workingdoc-consultation.pdf

Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

Association des Guides du Rwanda (AGR) is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

AGR is non-profit organization operating in Rwanda since 1980. It is a voluntary girl-serving organization dedicated to girls and young women. We offer a wide range of non-formal educational programmes and activities, encouraging girls and young women to develop their own special personalities, make a contribution to their community, and form friendships in a positive environment.

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

- A. 7 Points for Action Plan Improvement
 - 1. Ensure bold targets and ambition
 - 2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
 - 3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
 - 4. Ensure greater focus on the SAFER strategies;
 - 5. Ensure greater focus on governance and infrastructure improvements;
 - 6. Improve resourcing as well as reporting and review of implementation; and
 - 7. Update nomenclature in line with state-of-the-art evidence.

- B. Additional point to be added to the action plan
 - 1. Suggestion for elements of the action plan

- C. Point of criticism and request for significant change
 - 1. Role of the alcohol industry, conflict of interest

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome – and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstinence rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world’s children. The WHO–UNICEF–Lancet Commission is set to lay the foundations for a new

global movement for child health that addresses two major crises adversely affecting children's health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.

- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

Where possible, actions and key indicators should be time-bound.

4. Ensuring greater focus on the SAFER strategies

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions – to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol.

We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys – that has largely fallen short of necessity – is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document.

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements – learning lessons from other health areas.

Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.

7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings – like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals – like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO’s expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

Regarding the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called “Infrastructure”.

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential – as tobacco control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden.

For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level.

We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through "SAFER pilot countries".

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial – both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets
2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.
3. Framework for action
 - Operational objectives: 8
 - Priority areas for global action: 6
 - Global action: WHO
 - National action: Member States

4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Association for Prevention of Alcohol Misuse (APAM)

Country/Location: Malaysia

Submission

Associated to alcohol use are not "only" the health and social harms, but also economic and sustainable development harms. We suggest including cultural harms and consequences, particularly when considering Indigenous communities and diverse populations. In many locations there are significant micro-cultural differences and influences in some communities and countries. Introduction of western style, mass produced alcoholic beverages has seen a loss of connection to culture in many locations. Colonisation and settler cultures have influenced dramatic changes and loss of identity in some communities across the globe, particularly amongst younger people who have been strongly influenced by access to the internet, media and targeting by international alcohol companies, and social media.

Attachment(s): 1

00426_61_apam-updated-action-plan-consultation-dec2020.pdf

Submission from ASSOCIATION FOR THE PREVENTION OF ALCOHOL MISUSE

WHO Web based consultation 16 November – 13 December 2020

Working Document to develop an action plan for improving WHO global alcohol strategy implementation

We are grateful for the opportunity to comment on the working document and appreciate the effort by WHO in conducting an ambitious consultative process. We have reviewed the document and have the following comments and suggestions for your consideration.

We are a non-governmental organization in Borneo, Malaysia, that focuses on providing various harm reduction, motivational interview-based psychological interventions, and mindfulness interventions at various levels, especially at primary prevention. We have developed a unique circus-based mindfulness program that can be used to deal with the urge surfing that accompanies alcohol addiction; a peer-based community motivational interviewing programme that is a knowledge transfer to the community in order to empower local communities to handle psychological sequelae of alcohol use; and also a knowledge transfer programme called the “Alcohol Toolkit” that is available in indigenous languages.

In our submission we will first outline a few key points, then we go on to give more detailed comments and proposals on the different parts of the working document.

Thank you for your consideration.

Yours sincerely,

HELEN BENEDICT LASIMBANG
PRESIDENT

Association of Prevention of Alcohol Misuse

Key comments

1. **We strongly disagree with the role assigned to the alcohol industry** in the working document, especially in the key areas for global action. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.
2. **We propose bold, ambitious overall targets** of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.
3. **We caution against the description of alcohol harm as “complex” problem** because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol issues. We further propose to remove two other points in the list of challenges (see detailed description below).
4. **The absence of a global, legally binding instrument**, leading – among other things – to a lack of protection from alcohol industry interference, is the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).
5. **Associated to alcohol use are not “only” the health and social harms**, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.

Detailed comments on the working document

In general, we welcome and support large parts of the working document as elements of the future action plan.

Regarding Setting the scene

We support the focus on strengthening global action, building on the mandate that Member States have given WHO in 2010 and that Member States have renewed with the WHO governing body decisions in 2019 and 2020.

Concretely, we welcome and support the effort to define clear targets and indicators.

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan. We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan (see below).

We welcome and support the analysis of and emphasis on the potential of mainstreaming alcohol policy into other relevant policy sectors and to promote cross-sectorial work to advance alcohol policy development.

Fourthly, we welcome and support the emphasis on alcohol's role across the GPW13's triple billion target. This shows what the potential of this new alcohol action plan could be: to strengthen the mandate and case for global action on the entirety of alcohol harm – in this way unlocking the full potential of alcohol policy solutions.

Proposing a bold overarching target

While we welcome and support the global action area targets and the indicators listed in Annex I, we miss one overarching target that underpins the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries.

Placing SAFER front and center

The setting the scene section can be improved by placing the SAFER alcohol policy blueprint front and center. The case for action and the return on investment should be made clear from the

outset: Implementation of the three best buys would result in a return on investment of \$9 for every \$1 invested. Already in 2010, the WHO Global Health Report outlined that:

“Raising taxes on alcohol to 40% of the retail price could have an even bigger impact [than a 50% increase in tobacco taxation]. Estimates for 12 low-income countries show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries “

This locates the alcohol action immediately within wider efforts to achieve universal health coverage and to reach the SDGs.

Regarding the WHO GAS implementation

We support the analysis of the last ten years of WHO GAS implementation around the world.

While we do not disagree with the presentation of the evidence, we ask for stronger conclusions and clearer messages regarding the evaluation of the decade of WHO GAS implementation in this section.

WHO GAS implementation over the last ten years has been ineffective, inadequate and outdated. Some of the evidence should be presented to set the scene for the action plan.

- Alcohol availability regulation remains inadequate, according to findings from the WHO Global Alcohol Status 2018, to compound the situation, alcohol is actually becoming more widely and easily available. The number of licenses to produce, distribute and sell alcohol – a marker for increased rather than decreased availability – is increasing in much of the world, particularly in lower-income countries.
- Levels of treatment coverage vary substantially across countries but are inadequate across the world. Only 14% of reporting countries indicated high treatment coverage, and 28% of reporting countries indicated very limited or close to zero treatment coverage.
- Alcohol marketing regulations remain inadequate, too. Digital alcohol marketing restrictions are far behind technological innovation in the alcohol industry. 28% of countries had no regulations on any media type in 2016, most of them being located in the African or Americas regions.
- While 95% of all reporting countries implement alcohol excise taxes, fewer than half use the other price strategies highlighted in the WHO GAS – such as adjusting taxes to keep up with inflation and income levels, imposing minimum pricing policies, or banning below-cost selling or volume discounts. This shows that alcohol pricing policies remain inadequate. For example, in 2017 only 59% of responding countries had implemented a tax increase on alcoholic beverages since the adoption of the WHO GAS. Only a third of countries adjust those taxes regularly for inflation, and eight countries (five of them in the WHO European Region) reported increasing their subsidies for alcohol production.

It is important that this analysis is added to the chapter about WHO GAS implementation. It is an understatement to conclude that implementation has been “uneven”. The evidence shows that the majority of countries falls short of adequately responding to the alcohol burden with the most cost-effective and impactful alcohol policy solutions.

Protecting children, youth and adults who don't use alcohol

We welcome and support the discussion of the alcohol abstaining population in the world. Protecting children, youth and adults from pressures to start consuming alcohol and in their non-consuming behaviour is a guiding principle of the WHO GAS.

Regarding WHO GAS implementation challenges

We welcome and support the analysis of the challenges that WHO GAS implementation was faced with over the last decade. We note that WHO examines 15 challenges.

The reason why this section is so important is that it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective, inadequate and outdated.

We propose to remove three items from the description of the challenges for WHO GAS implementation: Number one, two and three.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol (health) issues.

Secondly, while there might be differences between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention are equally able to take political action to reduce their alcohol burden.

Thirdly, we understand that intersectoral approaches to societal problems are not easy, but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

A more systematic order of implementation challenges

Not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels

5. Policy incoherence

Protection against alcohol industry interference

Alcohol remains the only psychoactive substance that is not under any binding international control regime, despite its massive global burden. Therefore, protections against alcohol industry interference are missing and pose the biggest challenge to WHO GAS implementation.

The alcohol industry deploys its political, market and purchase power to interfere in public health policymaking in order to delay, derail and destroy alcohol policy-making efforts. They also leverage aggressive marketing spending, for example in the digital world – as the coronavirus crisis has brought into sharp focus, and they deploy corporate social responsibility schemes to white-wash their image, cultivate relationships and avoid statutory public health policies.

We urge for such a description to be added to the next document. Ten years of evidence from attempts to implement the WHO GAS have contributed compelling evidence.

Regarding WHO GAS implementation opportunities

We welcome and support the analysis of the opportunities for preventing and reducing alcohol harm; but the section should be better framed as opportunities to accelerate action on WHO GAS implementation (as are the challenges) – as called for by Member States.

We agree with all the opportunities outlined in the working document. The reason why this section is so important is that it provides context for global and national action to capitalize on these opportunities.

Regarding Scope of the action plan

We welcome and support the scope of the action plan to comprise concrete action and significant improvements to the global governance of alcohol policy development. Importantly, we welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

We support and welcome the actions suggested for Member States and the WHO. Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. But we support the ambition, quantity and quality of the actions outlined because it signifies Member States' obligation to ensure their citizens are protected from alcohol harm. The proposed actions also illustrate that it is WHO's responsibility to live up to the strong mandate it has received in 2010 and on different occasions since then.

All stakeholders are not equal

In this context, we must highlight that all stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the

public interest in protecting people, communities and societies from alcohol harm. There is a fundamental conflict of interest on part of the alcohol industry.

Clearly, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world (see above). Therefore, we make concrete suggestions for how the role of different stakeholders can be better reflected in the action plan.

Regarding Goal of the action plan

We welcome and support the reiteration of the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We suggest including the health, social, economic and sustainable development consequences of alcohol but we fully endorse this overarching goal.

What we want to improve

There needs to be a section/ chapter dealing with the vision, mission and targets of the action plan. Goals and implementation could be kept separate for purpose of clarity.

Commenting on the formulation of the goal: Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences of alcohol in the description of the goal.

Regarding Proposed operational objectives

We welcome and strongly support the action-oriented nature of the working document’s outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions.

In support of the operational objectives, we propose a logical model, and we propose adding two more operational objectives that have gone missing from the WHO GAS’ objectives.

What we want to add

We propose to add two more operational objectives. Our analysis of the working document and the WHO GAS has shown that some elements of the original objectives went missing. While we support the operational objectives as suggested in the working document, we are convinced that the following elements should also be included in the action plan’s operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Objective 8 builds on missing elements contained in WHO GAS objective 4.

Regarding proposed key areas for global action

Broadly, we welcome and support the set of 6 key areas for global action, including the quantity and quality of the actions detailed. Some elements can be improved, some elements are missing, and some elements should be reworked while some others should be removed – as outlined in Movendi International’s submission, which we endorse.

We propose to reframe and rework the key areas for global action as “framework for action”, as for example the WHO Global Action Plan for Physical Activity (GAPPA) does. This allows to streamline the actions and create greater coherence across the action areas.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO. Therefore, we propose to include civil society and international partner action in a separate section and to focus Member States and WHO action in the “Framework for action”.

Global action on reporting about alcohol consumption, related harm and policy development should reflect the magnitude and urgency of addressing the alcohol burden. In tobacco control, a global report is launched every year. For alcohol prevention and control that should be the ambition, too.

Role of the alcohol industry

We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. The working document remains incoherent, as is the WHO GAS.

It is critical that the action plan overcomes this incoherence within the frames of the mandate given by Member States through the WHO GAS but in line with a decade of evidence about the alcohol industry’s role in delaying, derailing and destroying attempts to implement the WHO GAS.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol

policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Regarding improvements to the global governance and infrastructure for alcohol policy development

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitating leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. The reasons are clear and have indirectly addressed in the working document. Therefore, we are convinced that the action plan benefits from including a section about infrastructure and governance improvements – applying lessons learned from other health areas.

Examples of such infrastructure on the level of global action could be:

- A global ministerial conference on alcohol under the guidance of WHO
- A Global Fund for Alcohol Prevention
- A global initiative to advance alcohol taxation
- A functioning international network of alcohol focal points, like there is for NCDs government focal points
- A mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals
- Civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues
- A specific WHO program on alcohol to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called “Infrastructure”.

Association of Advocates against Alcohol Harm in Nigeria

Country/Location: Nigeria

Submission

The Association of Advocates against Alcohol harm in Nigeria (ASAAHN) is a coalition of civil society organizations whose primary objective is to advocate for the development, adoption and implementation of an effective alcohol policy in Nigeria. Currently, there is no policy document in Nigeria.

ASAAHN recommends 3 major points to strengthen the action plan;

1. The Economic operators ie Alcoholic industries should not be included as stakeholders together with CSO and other actors.
2. Regular reporting by the Director General to the World Health Assembly biannually on the progress made
3. Need to adopt and encourage the SAFER policies in national alcoholic policies.

Attachment(s): 1

00220_32_asaahn-submission-to-the-who-web-consultation-on-the-global-strategy-to-reduce-the-harmful-effect-of-alcohol.pdf

Association of Advocates Against
Alcohol Harm in Nigeria
Lagos , Nigeria
drfrank.umenze@gmail.com
asaahn19@gmail.com

07 December 2020

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organisation (WHO)
Avenue Appia 20 1211 Geneva

Dear Director-General,

Submission on the Working Document for the development of an Action Plan to strengthen implementation of the WHO Global Alcohol Strategy (Working Document)

We have reviewed the Working Document for the development of an action plan to strengthen implementation of the WHO Global Alcohol Strategy (WHO GAS) and have the following comments and suggestions for your consideration.

The Association of Advocates Against Alcohol Harm in Nigeria (ASAAHN) is a coalition of civil society organizations whose objective is to advocate for a national alcohol policy formulation and adoption in Nigeria. We have constantly engaged the Federal Ministry of health and the WHO Nigeria office on developing a national alcohol policy in Nigeria. The first national stakeholders meeting occurred in June 2019 with the production of a draft policy document currently being reviewed by a consultant. ASAAHN hopes to continue her advocacy by engaging the ministry of health and the WHO Nigeria office.

Target 3.5 of the United Nations Sustainable Development Goals 2030 includes the objective of strengthening the prevention and treatment of substance abuse, including the harmful use of alcohol. The vision behind the *2010 Global Strategy to Reduce the Harmful Use of Alcohol* is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to alcohol and the ensuing social consequences.

ASAAHN has seen unregulated alcohol advertisement and endorsement by celebrities, road traffic crashes caused by drink driving, unrestricted access to alcoholic retail stores, reduced DALYS ,gender based violence and crime caused by the harmful effect of alcohol consumption. More worrisome is the lack of an effective policy to control these harmful effects. Nigeria with a population over 200 million and a greater percentage being youths under 35 years provides a huge market for the alcohol industry. There is also the problem of illegally brewed alcoholic sachets commonly sold around motor parks and schools.

An effective Action Plan is needed to strengthen the Global Strategy

The implementation of the Global Strategy has been uneven across the WHO regions. Between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita. Implementation of the alcohol policy best buy solutions has been insufficient in most countries around world over the last ten years. The alcohol industry has continued to interfere in alcohol policy-making processes. Therefore, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, alcohol caused three million deaths worldwide. Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. Without a clear Action Plan, the Global Strategy will remain unrealized and the health, social, economic and development harms of alcohol consumption will remain high and continue to be an obstacle to achieving the Sustainable Development Goals.

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan.

Strengths of the Action Plan include:

- The focus on the *'Implementation of High-Impact Strategies and Interventions'* or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.
- The inclusion of an objective focusing on prevention and treatment capacity being an integral part of universal health coverage.

There are also areas where the Action Plan can be strengthened, including:

- Streamlining the global actions actions by avoiding repetition, reducing overlap and adding prioritization
- Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm
- Dealing with the alcohol industry in a single paragraph due to their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does.
- Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.
- Biannual reporting by the DG to the WHA on the progress made.

Getting this action plan right will greatly support the push by ASAAHN to have a policy document for Nigeria.

Thank you for your consideration.

Yours sincerely,

Dr Franklin Umenze
Executive Director
Association of Advocates Against Alcohol Harm in Nigeria (ASSAHN)

Associazione Italiana Disordini da Esposizione Fetale ad Alcol e/o Droghe (AIDEFAD - aps)

Country/Location: Italy

URL: www.aidefad.it

Submission

We strongly suggest as necessary to include the effects of alcohol use during pregnancy as a key topic in the action plan. Alcohol use during pregnancy is a leading cause of non genetic neurodevelopmental disorder worldwide and it must be addressed to successfully reduce the harmful use of alcohol

Attachment(s): 0

Aston Kuseka Innovations (A.K.Innovs)

Country/Location: Zambia

Submission

In my dual capacity as (1) the Director/Lead Creative for our aforementioned 'A.K.Innovs' enterprise, and (2) the Lead Campaigner for our enterprise's own 'Global Alco-War Crusade' initiative, I do hereby humbly submit our SUGGESTION that: The UN, INEBRIA and other concerned stakeholders/actors prioritize the formation of our herein-proposed Global 'Ex-Partakers of Alcohol and Tobacco' Group (acronymed as the Global 'Ex-P.A.T' Group). In this context, this Group comprising Reformed Consumers, Abusers and Addicts "MUST BE DRILLED, ARMED, MANDATED AND DEPLOYED TO FRONTLINE THE 21ST CENTURY GLOBAL WARFARE AGAINST THE ESCALATING HARMFUL USE OF ALCOHOL." We remain ready to provide the finer conceptual details of our suggestion. Thank you.

Attachment(s): 0

AUCKLAND REGIONAL PUBLIC HEALTH SERVICE

Country/Location: New Zealand

URL: <https://www.arphs.health.nz/>

Submission

In summary ARPHS's key recommendations are:

- ☑ Acknowledge the rights of indigenous people and prioritise actions related to reducing alcohol-related harm for this group
- ☑ Include an explicit equity lens within the Working Document
- ☑ Prioritise the implementation of the three 'Best Buys' as identified through the World Health Organisation's SAFER initiative
- ☑ Support Governments' efforts to minimise the influence of commercial actors by excluding the industry from involvement in the development of the Action Plan
- ☑ Utilise the current process of developing an Action Plan as a stepping stone towards the development of an international treaty on alcohol control similar to the Framework Convention on Tobacco Control (FCTC)
- ☑ Include timeframes for reviewing and reporting on the implementation of the Action Plan
- ☑ Prioritise and lead communication regarding alcohol-related cancer risks

Attachment(s): 1

00299

11 December 2020

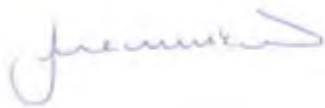
To the World Health Organisation Secretariat,

Feedback on the WHO Action Plan (2022-2030) to effectively implement the Global strategy to reduce the harmful use of alcohol

Thank you for the opportunity to submit on the World Health Organisation's consultation on the development of an Action Plan (2022-2030) to implement the Global Strategy to Reduce the Harmful Use of Alcohol.

The following submission represents the views of Auckland Regional Public Health Service (ARPHS) and does not necessarily reflect the views of the three district health boards it serves. Please refer to Appendix 1 for more information on ARPHS.

Yours sincerely



Jane McEntee
General Manager
Auckland Regional Public Health Service



Dr Nick Eichler
Public Health Medicine Specialist
Auckland Regional Public Health Service

Introduction

Thank you for the opportunity for the Auckland Regional Public Health Service (ARPHS) to provide feedback on the World Health Organisation's (WHO) consultation on the development of an Action Plan (2022-2030) to implement the global alcohol strategy to reduce its harmful use. The extended deadline for making submissions enabled ARPHS to consider the proposals amidst the COVID-19 response.

The submission draws from ARPHS' experience in alcohol harm prevention and minimisation from a health promotion and regulatory perspective. ARPHS has a statutory role within the alcohol legislation in Aotearoa New Zealand, the Sale and Supply of Alcohol Act 2012. Our priorities include actively protecting and achieving equity for those most disadvantaged in our community including our indigenous population (Māori), reducing alcohol outlet density and other measures based on the WHO's SAFER initiative.

Background and summary of the key recommendations

1. Alcohol is not an ordinary commodity, particularly with regards to its consumption, creating a significant burden of harm to populations who consume it. This preventable burden of harm falls in Aotearoa New Zealand, disproportionately on Māori (New Zealand's indigenous people), young people and low socio-economic groups.¹
2. The New Zealand Health Survey (2019-2020) highlights 20.9 per cent of people surveyed had a hazardous drinking pattern, with men more likely to have a hazardous drinking pattern than women.²
3. Compared to other OECD countries, Aotearoa New Zealand has one of the highest rates of youth suicides and family and domestic violence.^{3,4} It is well established that the use of alcohol is a strong risk factor for both of these issues.⁵ From a public health perspective strong actions are therefore warranted in order to reduce suffering from high rates of suicide and violence in Aotearoa New Zealand.
4. ARPHS would therefore support strong, evidence-based actions that are free from interference from the alcohol industry, and that lead to a reduction of existing inequities amongst the various population groups.
5. In summary ARPHS's key recommendations are:
 - Acknowledge the rights of indigenous people and prioritise actions related to reducing alcohol related harm for this group
 - Include an explicit equity lens within the Working Document

¹ Ministry of Health. Annual Update of Key Results 2019/20: New Zealand Health Survey. 2020. Available via: <https://www.health.govt.nz/publication/annual-update-key-results-2019-20-new-zealand-health-survey> (accessed Dec 8, 2020).

² Ibid.

³ UNICEF. Building the Future: Children and the Sustainable Development Goals in Rich Countries: Innocenti Report Card 14. Florence, Italy: Author, 2017 https://www.unicef-irc.org/publications/pdf/RC14_eng.pdf (accessed Dec 3, 2020).

⁴ United Nations Human Rights Council. Report of the Working Group on the Universal Periodic Review: New Zealand. Author, 2019 <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/087/77/PDF/G1908777.pdf?OpenElement> (accessed Dec 3, 2020).

⁵ Ferrari AJ, Norman RE, Freedman G, et al. The burden attributable to mental and substance use disorders as risk factors for suicide: Findings from the Global Burden of Disease Study 2010. *PLoS One* 2014; 9: e91936.

- Prioritise the implementation of the three ‘Best Buys’ as identified through the World Health Organisation’s SAFER initiative
- Support Governments’ efforts to minimise the influence of commercial actors by excluding the industry from involvement in the development of the Action Plan
- Utilise the current process of developing an Action Plan as a stepping stone towards the development of an international treaty on alcohol control similar to the Framework Convention on Tobacco Control (FCTC)
- Include timeframes for reviewing and reporting on the implementation of the Action Plan
- Prioritise and lead communication regarding alcohol-related cancer risks

Recommendations

Recommendation 1: Acknowledge the rights of indigenous people and prioritise actions related to reducing alcohol related harm for this group

6. As the global lead agency on health matters, the World Health Organisation should acknowledge and champion action around improving the rights of indigenous people as reflected in the UN Declaration on the Rights of Indigenous People 2007.
7. In Aotearoa New Zealand, Māori are significantly more likely to drink hazardously than non-Māori, and they disproportionately carry the load of alcohol related harm⁶; living in closer proximity to alcohol outlets⁷ and being five times more likely to be exposed to alcohol marketing compared to their New Zealand European counterparts.⁸ Alcohol (waipiro in Te Reo Māori) was not present in Aotearoa New Zealand until colonisation began in the 1800s, and as such the entirety of the burden of alcohol-related harm for Māori is attributable to extrinsic factors.⁹
8. The drivers of alcohol-related harm for Māori are structural, and include the enduring marginalising and dispossessing effects of the colonisation of Aotearoa New Zealand, as well as present economic and housing policies that continue to exclude Māori from equal participation in society. Alcohol use in turn contributes to health and economic inequities experienced by Māori.¹⁰

⁶ Connor J, Kydd R, Shield K, Rehm J. The burden of disease and injury attributable to alcohol in New Zealanders under 80 years of age: Marked disparities by ethnicity and sex. *N Z Med J* 2015; 128: 15–28.

⁷ Ayuka F, Barnett R, Pearce J. Neighbourhood availability of alcohol outlets and hazardous alcohol consumption in New Zealand. *Health Place* 2014; 1: 186–99.

⁸ Chambers T, Stanley J, Signal L, *et al.* Quantifying the nature and extent of children’s real-time exposure to alcohol marketing in their everyday lives using wearable cameras: Children’s exposure via a range of media in a range of key places. *Alcohol Alcohol* 2018; 53: 626–633.

⁹ Hutt M. *Te Iwi Maori me te Inu Waipiro: He Tuhituhinga Hitori: Maori & Alcohol: A History*. Wellington: Health Services Research Centre, 1999.

¹⁰ New Zealand Law Commission. *Alcohol in our lives: curbing the harm*. Wellington: New Zealand Law Commission. 2010 Apr 27.

9. Moreover, the global COVID-19 pandemic has further exacerbated these existing inequalities, with a larger proportion of Māori drinking more heavily post lock-down when compared to pre-lockdown (22%) compared to Pacific peoples (10%) and non- Māori/non Pacific peoples (13%).¹¹
10. ARPHS therefore urges the WHO to honour its commitment to improving indigenous health and to utilise the development of the Action Plan as an opportunity to include specific actions and indicators that explicitly address and improve indigenous health globally.

Recommendation 2: Include an explicit equity lens within the Working Document

11. Following on from the previous recommendation, ARPHS believes that the Working Document could be strengthened with regards to the equity aspect. Whilst the Working Document notes the equity gap with regards to the implementation of effective policies between high- and low-income countries there is no specific mention of the inequities in alcohol related harm within countries.
12. Equity should be at the forefront of all decisions and actions by Member States and others and the impact of any interventions and policies implemented should specifically measure whether or not they reduce alcohol related inequities between and within countries.

Recommendation 3: Prioritise the implementation of the three ‘Best Buys’ as identified in the World Health Organisation’s SAFER initiative

13. ARPHS is of the view that the Action Plan should be framed around all Member States implementing the three ‘best buys’ as formulated in the WHO’s SAFER initiative being:
 - Increase the price of alcohol
 - Reduce the availability of alcohol
 - Restrict the marketing of alcohol
14. The implementation of these strategies should be monitored and reported on according to the monitoring indicators as identified under the SAFER implementation.

Recommendation 4: Support Governments efforts to minimise the influence of commercial actors by excluding the industry from involvement in the development of the Action Plan

15. In Aotearoa New Zealand calls from both local government actors as well as communities for greater control over alcohol licensing decisions have been repeatedly overshadowed by the legal resources of alcohol producers and retailers. The supermarket duopoly has regularly appealed local government efforts to limit alcohol outlet density and reduce trading hours.¹²

¹¹ Health Promotion Agency. Impact of COVID-19: Topline results - Wave 2. Wellington, N.Z: Author, 2020
<https://www.hpa.org.nz/research-library/research-publications/post-lockdown-survey-the-impact-on-health-risk-behaviours>
(accessed Oct 8, 2020).

¹² Maclennan B, Kypri K, Connor J, *et al.* New Zealand’s new alcohol laws: protocol for a mixed methods evaluation. *BMC Public Health* 2015, 16: 29, <https://doi.org/10.1186/s12889-015-2638-9>

16. ARPHS is therefore concerned to see alcohol industry entities listed in the Working Document as being stakeholders, and being given similar weighting as to civil society, government entities and NGOs. Given the industry's track record of often successfully opposing effective policy and the clear conflict of interest this is inappropriate.
17. As the world's leading health entity, ARPHS urges the WHO to lead by example and empower governments to put people's health before profits and exclude the industry from the development of an Action Plan.

Recommendation 5: Utilise the current process of developing an Action Plan as a stepping stone towards the development of an international treaty on alcohol control similar to the Framework Convention on Tobacco Control (FCTC)

18. As highlighted in the Working Document, alcohol remains the only psychoactive substance that lacks legally-binding regulatory instruments at an international level. The current process provides an opportunity to strengthen the governance of alcohol at a global level.
19. ARPHS would support a stronger global plan and a legally binding framework similar to the Framework Convention on Tobacco Control (FCTC). Both are urgently needed in order to combat the industry's opposition to regulation and the implementation of 'best buys' policies.

Recommendation 6: Include timeframes for reviewing and reporting on the implementation of the Action Plan

20. ARPHS would like to express its concern around the lack of detail around reporting expectations of Member States and the review process, including timeframes, of the Action Plan. Any reporting should include challenges faced by Member States and reporting on progress made with regards to addressing inequities.

Recommendation 7: Prioritise and lead communication regarding alcohol related cancer risks

21. Because of the low awareness of alcohol related cancer risks in Aotearoa New Zealand, ARPHS supports Action 2 of Action Area 2 (Advocacy, awareness and commitment), with the WHO proposing to take a leading role in developing communications and raising awareness around this topic.
22. This is particularly important as evidence shows that knowledge of alcohol-related cancer links is associated with an increase in public support for high impact, evidence-based alcohol policies.

Conclusion

23. Thank you for considering ARPHS' submission on the WHO Action Plan (2022-2030) to effectively implement the Global strategy to reduce the harmful use of alcohol.

Appendix 1: Auckland Regional Public Health Service

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Counties Manukau Health, Auckland and Waitematā District Health Boards).

Auckland Regional Public Health Service has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

Auckland Regional Public Health Service's primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, infrastructure requirements, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.

Austrian Economics Center

Country/Location: Austria

URL: <https://www.austriancenter.com>

Submission

The World Health Organization (WHO) recently published the Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol which details the WHO global action plan to re-position its goals toward alcohol within the framework of the 2030 Agenda for Sustainable Development. In the working paper, the agency lays out recommendations for taxation on alcohol at all possible levels of governance as well as bans on the advertisement of alcohol in realizing those goals.

Compared to the 2010 version of the Global Strategy, this version sets a puzzling new direction that de-emphasizes the public health perspective of the harmful effects of alcohol and rather focuses instead on the commercial side, targeting the sale and distribution, availability and access, and marketing aspects. Along with illogical lines of reasoning and the glaring overstep of authority that would occur if the WHO were to implement it, the plan has the potential to cause additional harm and bring about unintended consequences if it pursues this ill-conceived direction.

The taxation of alcohol is first in the line of unintended consequences. Most directly, such a tax would affect the whole supply chain with increases in prices paid by consumers, whether they drink responsibly or not, and strike revenues of brewers and distillers of alcoholic beverages, bars, restaurants, and shops that carry the beverages, and advertising agencies that promote them. Aside from the dubious claims of taxation for the sake of revenues toward remedying the harmful effects of alcohol, this type of policy is inherently prohibitive in its scope. As seen during the time of Prohibition in the United States, the black market and involvement of violent criminal organizations caused enormous harm across American society. In more recent times, the criminalization of cannabis gave rise to legal alternatives in the form of a synthetic version that turned out to have a range of adverse effects. And similar efforts when it comes to tobacco has equally incentivized more dubious actors while penalizing responsible businesses.

The 2020 working paper makes less of a mention of illicit and informal alcohol in the world than the 2010 version despite its implications. If the goal is to reduce the harmful effects of alcohol, then minimizing the role of harmful consumption would be ideal, e.g., through a great focus on better health care and stricter drunk-driving laws. Unfortunately, the policies recommended in the working paper would likely have the opposite effect as suggested by historical example where illegal or informal alternatives are sought in the wake of interventionist policies that throttle availability.

At the heart of the matter, the 2020 Global Strategy problematizes the consumption of alcohol as a whole rather than the harm that can potentially come about due to alcohol consumption. The wrongdoing of a drunk driver does not imply the necessity to punish all those who responsibly consume alcohol. This working paper's recommendations essentially aim to cut down the general consumption of alcohol in an effort to cut down on the many real deleterious effects that alcohol can cause rather than drawing up ways to address those problems.

Philosophically, the issue encompasses the extent of the role of governance bodies such as state governments and intergovernmental organizations in determining the merits of the various things that people can ingest. In his 1927 book *Liberalism: The Classical Tradition*, Ludwig von Mises takes the argument to its logical conclusions, stating, "Why should not what is valid for these poisons be valid also for nicotine, caffeine, and the like? Why should not the state generally prescribe which foods may be indulged in and which must be avoided because they are injurious?"

While the proponents of a global alcohol tax for the purpose of curbing the harmful effects of alcohol consumption may seriously take such questions into account, they highlight obvious avenues toward infringement on the freedom and responsibility of individual persons in choosing what to consume. Indeed, such paternalistic efforts deny individuals of their personal capability to make their own decisions and be responsible citizens.

As opponents of government's role in lifestyle matters have often argued in the past, this working paper also shows how no area of consumption and lifestyle is save from regulatory attempts. First it was tobacco - which restrictions and prohibitions the WHO's new effort on alcohol seem modelled after - then sugar, and now alcohol. The question that naturally arises is what were to come next, as this ripple effect could slowly encompass all types of decisions that should more generally be the consumer's choice to make.

In short, the WHO may release a working paper for what it deems proper for the future of alcohol consumption in the world, but it would be hard-pressed to justify such an authority to enforce it.

Attachment(s): 0

Balance

Country/Location: United Kingdom of Great Britain and Northern Ireland

URL: www.balancenortheast.co.uk

Submission

We support the submissions of IAS and the Alcohol Health Alliance UK. We welcome the WHO global strategy and 'best buys' and have included various suggestions in the attached letter.

Attachment(s): 1

00441_74_final-balance-letter-who-gas.pdf

Balance,
Salvus House
Aykley Heads
Durham

7th December 2020

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organisation (WHO)
Avenue Appia 20 1211 Geneva

Dear Director-General,

Submission on the Working Document for the development of an Action Plan to strengthen implementation of the WHO Global Alcohol Strategy (Working Document)

We have reviewed the Working Document for the development of an action plan to strengthen implementation of the WHO Global Alcohol Strategy (WHO GAS) and we would like to endorse the responses from the Institute of Alcohol Studies and the Alcohol Health Alliance, of which Balance is a member. We also have a number of comments and suggestions for your consideration.

Balance is an alcohol programme, based in the North East of England, which adopts an evidence-based approach to tackling alcohol-related harms. We work at a population level across seven local authorities, delivering award winning mass media campaigns and raising awareness of harms associated with alcohol. Balance does not have any direct or indirect links to, or receive funding from, the alcohol industry or their affiliates.

Alcohol causes a huge range of harms in England and the North East suffers disproportionately, with the highest rates of alcohol-related hospital admissions and deaths. Alcohol was estimated to cost North East public services and employers around £1.01bn in 2015/16, including £209 million to the NHS and healthcare for services such as hospital admissions, A&E attendances, ambulance callouts and also treatment for alcohol dependency, and £331 million in crime and disorder, including 55,300 cases of criminal damage, 154,900 cases of theft and 20,000 cases of violence against the person.

It has been estimated that half of the burden of disease in this country is preventable.¹ Much of that comes from alcohol: for example, it is the leading risk factor for death and illness among 15-to-49-year-olds in England and more working years of life are lost in England because of alcohol-related deaths than from the ten most prevalent cancers combined.²

The ongoing COVID-19 pandemic has highlighted health inequalities. COVID-19 infection and death rates in deprived communities with higher levels of poor health are disproportionately higher than those of less deprived communities.³ Cultural-behavioural factors such as alcohol consumption, smoking, exercise and diet are known to fuel health inequalities. The North East suffers poor outcomes across a range of issues due to health and social inequality and alcohol harms are

¹ DHSC (2018). [Prevention is better than cure](#).

² PHE (2016) [The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies](#)

³ Public Health England (2020). [Disparities in the risks and outcomes of COVID-19](#).

particularly pronounced in the region. This is why we feel it is important for Balance to respond to this consultation and help to shape policy at a global level.

An effective Action Plan is needed to strengthen the Global Strategy

The implementation of the Global Strategy has been uneven across the WHO regions. Between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita. Implementation of the alcohol policy 'best buy' solutions has been insufficient in most countries around world over the last ten years. The alcohol industry has continued to interfere in alcohol policy-making processes. Therefore, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, alcohol caused three million deaths worldwide. Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. Without a clear Action Plan, the Global Strategy will remain unrealized and the health, social, economic and development harms of alcohol consumption will remain high and continue to be an obstacle to achieving the Sustainable Development Goals.

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan. We believe that strengths of the Action Plan include:

- The focus on the '*Implementation of High-Impact Strategies and Interventions*' or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.
- The inclusion of an objective focussing on prevention and treatment capacity being an integral part of universal health coverage.

There are also areas where we feel that the Action Plan could be strengthened, including:

- Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization.
- Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm.
- Dealing with the alcohol industry in a single paragraph due to their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does.
- Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.

We hope these suggestions are useful and we are hugely supportive of the WHO's desire to place a clear strategy and evidence based practice at the heart of its alcohol prevention policies. At a North East level, we see every day the harm that alcohol causes to our families and communities and we believe that the WHO has an integral role to play in terms of shaping policy and providing a framework for countries to work more effectively to combat alcohol harms. The UK Government does not have a current alcohol

strategy and in England, harms are increasing, due to the failure to introduce a Minimum Unit Price for alcohol and the effects of successive cuts in alcohol tax. The world is at a turning point when it comes to the prevention agenda and, certainly in England, there is a danger that alcohol will be left behind. We believe that the WHO can help prevent this from happening, by driving evidence based action from member states across the globe.

Thank you for your consideration.

Yours sincerely,

Sue Taylor
Strategic Partnerships Manager
Balance
Susan.taylor@fresh-balance.co.uk

Beer Canada

Country/Location: Canada

URL: <https://industry.beercanada.com/>

Submission

Beer Canada is the national voice of the Canadian brewing industry. Our diverse members collectively account for nine out of 10 beers brewed in the country. There are today more than 1,120 brewing facilities in Canada, ranging in size and complexity and covering hundreds of communities across the country. Beer is a popular beverage among Canadian adults and Canada has a long and rich brewing history that can be traced back more than 350 years.

SUMMARY

Beer Canada appreciates the opportunity to respond to the WHO Working Document: Development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol. The Global Strategy is a key achievement in the shared goal of reducing harmful alcohol use, and complementary to Canada's robust beverage alcohol control environment. Data released by the WHO and in Canada indicate reductions in harmful alcohol use. The Global Strategy is working, and progress is being made. To build on this effort and to accelerate progress, Beer Canada offers the following recommendations for the WHO:

1. That the Working Document be completely re-adjusted to fully align with the Global Strategy by: supporting the Strategy's flexible menu of policy options appropriate to national, cultural, regulatory and local context; placing the focus on the objective of reducing harmful alcohol use and not alcohol consumption per se; and recognizing economic operators as full partners and important to success, also aligning with the 2018 UN Political Declaration on Non-Communicable Diseases.
2. That the Working Document recognizes lower alcohol content beverages can reduce harmful alcohol use and recommends policy options that expand the adoption of low and no-alcohol products, including a policy mix that differentiates between higher alcohol and lower alcohol content beverage alcohol types; consistent with this, that the Working Document encourages the collection and refinement of data as appropriate to factor in or track differential impacts.

An action plan which fully aligns with the Global Strategy will be more successful than one that does not, given the progress already made in reducing harmful alcohol use and alcohol-related harm under that Strategy. By excluding industry from key areas of engagement and discussions, the Working Document invalidates core principles of the Global Strategy and the 2018 UN Political Declaration on Non-Communicable Diseases, undermining the shared objective of reducing the harmful use of alcohol.

Brewers, who are part of local communities across Canada as well as in other countries throughout the world, are well positioned to not only complement and inform but also amplify efforts to reduce harmful alcohol use. Growing evidence indicates that regulatory environments should be designed to favor products with lower alcohol concentration. Consistent with the Global Strategy, the Working Document should recognize and recommend policy options that expand the adoption of low and no-

alcohol products, including a policy mix that differentiates between higher alcohol and lower alcohol content beverage alcohol types.

We hope that our comments and recommendations will be helpful to the process of developing a Global Strategy Action Plan. A detailed discussion can be found in our submission.

Attachment(s): 1

00201_21_201209-beer-canada-submission-to-the-who-re-working-document-on-developing-a-global-strategy-action-plan.pdf



P.O. Box 654
Ottawa, Ontario
K2S 1A7

☎ 1 613.232.9601

Industry.beercanada.com

December 9, 2020

Dr. Vladimir Poznyak
Unit Head, Alcohol, Drugs and Addictive Behaviours
World Health Organization

Mr. Dag Rekve
Senior Technical Officer, Alcohol, Drugs and Addictive Behaviours
World Health Organization

RE: Consultations on a WHO Working Document to Develop a Global Alcohol Strategy Action Plan

Dear Dr. Poznyak and Mr. Rekve:

Beer Canada appreciates the opportunity to respond to the *WHO Working Document: Development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol*. We support the Global Strategy and the creation of an action plan but are concerned as the Working Document invalidates core principles of the Strategy, as well as misses opportunities to support promotion of products with a lower concentration of alcohol as an effective policy option in reducing the harmful use of alcohol and alcohol-related harm.

INTRODUCTION

The Global Strategy is a key achievement in the shared goal of reducing harmful alcohol use, and complementary to Canada's robust beverage alcohol control environment. The WHO Global Status Report on Alcohol and Health 2018 shows that from 2010 to 2016 heavy episodic drinking among adults and alcohol-related mortality and morbidity declined in most WHO regions, and in many instances, with declines meeting or exceeding a target of a relative reduction at the global average of at least 10%. Decreased alcohol consumption among youth also was observed in a wide range of countries.

According to other global data, including for Canada, underage drinking has declined in over two-thirds of the 63 countries being mapped, while drinking driving fatalities have also fallen in 34 out of the 36 countries where national trend data is available (IARD Trends Reports 2019). The Public Health Agency of Canada in Health Behaviour in School-Aged Children in Canada (HBSC, 2015) indicates a decline in underage drinking between 2010 and 2014. Statistics Canada's Incident-based Crime Statistics show that the rate for alcohol-impaired operation of a motor vehicle fell by 23.2% since 2010.

Over the past decade, the Canadian government has tightened impaired driving provisions closing loopholes and increasing penalties. Other initiatives include new rules for alcohol/highly sweetened products to limit alcohol content. Provincial and territorial governments have strengthened drinking and driving administrative sanctions, and have initiated actions that include: mandatory server training and employee training programs, ID Check 25 programs which ask customers who appear to be under the age of 25 to provide proof of age, multi-year campaigns intended to raise awareness about the risks of providing alcohol to minors and underage drinking, and high-profile responsible drinking advertising to help prevent drinking driving. The Canadian brewing industry has also contributed to progress, and this is discussed further in this submission.

While the Working Document highlights reductions in harmful use of alcohol, it quickly dismisses or downplays positive trends. It is not clear why these achievements are minimized, when in fact the data show that the Global Strategy is working, and progress is being made. To build on this effort and to accelerate progress, Beer Canada offers the following recommendations for the WHO.

RECOMMENDATIONS

- 1. That the Working Document be completely re-adjusted to fully align with the Global Strategy by: supporting the Strategy's flexible menu of policy options appropriate to national, cultural, regulatory and local context; placing the focus on the objective of reducing harmful alcohol use and not alcohol consumption per se; and recognizing economic operators as full partners and important to success, also aligning with the 2018 UN Political Declaration on Non-Communicable Diseases.**
- 2. That the Working Document recognizes lower alcohol content beverages can reduce harmful alcohol use and recommends policy options that expand the adoption of low and no-alcohol products, including a policy mix that differentiates between higher alcohol and lower alcohol content beverage alcohol types; consistent with this, that the Working Document encourages the collection and refinement of data as appropriate to factor in or track differential impacts.**

ALIGNMENT WITH THE GLOBAL STRATEGY

Menu of Policy Options As Appropriate to Context to Reduce Harmful Use of Alcohol

The Working Document promotes and elevates over other possible interventions the SAFER initiative, a narrow and prescriptive approach which includes as policies, higher taxes, advertising bans, and increased restrictions on availability. SAFER has not been endorsed by Member States, and its positioning as a priority action invalidates the Global Strategy's flexible menu of policy options appropriate to national, cultural, regulatory and local context. The Global Alcohol Strategy recognizes that "one size does not fit all", and that context is a determining factor in choosing optimal policy measures and interventions.

Blunt highly restrictive policies like increased alcohol taxes may also lead to unintended consequences such as the growth in the illicit alcohol market. The unintended effects of these policies on the illicit alcohol market are not explored by the Working Document, which also does not consider how targeted and smart tax policies can be used to draw consumers away from inexpensive illicit high-strength products to inexpensive licit lower alcohol products (Artyom G. et al., Report, 2016).

The Working Document also calls for the use of earmarked alcohol tax revenues to fund programs, and an increase in the number of countries adopting this measure as a target. The WHO, however, in previous documents has noted an active debate on earmarked tax revenues with advantages and disadvantages, the latter with respect to budget rigidities and inefficient allocation of resources (WHO, Arguments For and Against Earmarking). Earmarking tax revenues also has little empirical effect on amounts actually spent, and it may reduce accountability (Richard M. Bird, World Bank Working Paper, 2015).

In addition, the Working Document sets a reduction in alcohol per capita consumption as a target, instead of agreed-upon measures of harmful alcohol use – heavy episodic drinking, alcohol-related mortality, and alcohol-related morbidity. Consistent with the Global Strategy, the focus should remain solely on reducing harmful alcohol use, rather than referencing the reduction of alcohol consumption per se. The positioning of alcohol consumption in the Working Document as inherently harmful ignores the protective effect observed for alcohol's impact on ischaemic stroke and diabetes at the global level, as noted in the WHO's 2018 Global Status on Alcohol and Health.

Brewing Industry Contributions

Brewers, who are part of local communities across Canada as well as in other countries throughout the world, are well positioned to not only complement and inform but also amplify efforts to reduce harmful drinking. Beer Canada and its members continually work toward promoting a culture of moderation in Canada which is a key goal of Canada's National Alcohol Strategy, by investing in partnerships with organizations that are leaders in their field, like the Traffic Injury Research Foundation, and by working with the Canadian Centre on Substance Use and Addiction (CCSA) and other stakeholder groups to fulfil National Alcohol Strategy recommendations, including promotion of Canada's Low Risk Drinking Guidelines, and policy options to create incentives for choosing beers and coolers with lower alcohol content.

Beer Canada's [Responsible Advertising and Marketing Code](#) is a visible demonstration of the beer industry's shared commitment that advertising and marketing be directed only to those of legal drinking age and in a socially responsible manner. In Canada and abroad, beer producers are committed to combatting harmful drinking including increasing their focus on reducing global underage drinking and accelerating work in the digital space to restrict access to those underage, also encompassing the area of e-commerce and preventing the online sale and delivery of alcohol to minors.

Efforts involving a whole of society approach and multi-stakeholder support are likely to be more successful than those restricted to a limited group. The Working Document, however, portrays economic operators as obstructive to public health interests, citing “industry interference” as a basis for exclusion from engagement in discussions and for limiting dialogue. This marginalization of industry invalidates the core principles of the Global Strategy which identifies economic operators as “essential for success”, and the 2018 UN Political Declaration on Non-communicable Diseases which calls for engagement with the private sector for “its meaningful and effective contribution to the implementation of national responses to non-communicable diseases”.

The exclusion of industry from key areas of engagement will result in missed opportunities in achieving the shared objective of reducing the harmful use of alcohol, where the brewing sector with its familiarity of local realities can find common ground with public health. The Working Document should be readjusted to align with the Global Strategy and the 2018 UN Political Declaration on Non-Communicable Diseases, adopting a whole of society approach which sees dialogue with industry as an opportunity to build on private sector expertise.

DIFFERENTIATION AND REDUCTION OF ALCOHOL RELATED HARM

Researchers and policy experts have identified policies designed to steer consumers toward products with a lower concentration of alcohol to support public health objectives. In a recent case study from Great Britain, Peter Anderson et al. (Alcohol & Alcoholism, 2020) studied the effects of lower-alcohol products in the marketplace and concluded that regulatory environments should be designed to favor products with lower alcohol concentration.

Over the last decade, the brewing sector has developed, produced and promoted new low and no-alcohol beer brands, consistent with the Global Strategy’s call to economic operators to find ways to prevent and reduce harmful use of alcohol, and also consistent with Canada’s National Alcohol Strategy which recognizes the benefits of promoting the production and marketing of lower alcohol content beers and coolers through policy options.

Currently in Canada, no-alcohol beer products are subject to excise, and excise reductions are only available for products up to 2.5% alcohol by volume (abv). Beer Canada has worked to develop a consensus position among brewers in Canada on a recalibrated federal excise proposal to eliminate the excise on no-alcohol beer while introducing reductions in the lower alcohol content beers up to 3.5% abv.

These proposed excise changes are intended to support innovation in the beer category while at the same time moving consumption in the direction of lower alcohol products, thereby advancing a key National Alcohol Strategy recommendation, as well as the following recommendation from Canada’s House of Finance Committee to:

Encourage Canadians to lead healthy lifestyles by reducing the excise duty rates applicable to beer products at or below 3.5% abv and exempting non-alcoholic beer products from excise duties in order to stimulate growth and investment in this underdeveloped space of Canada's beer market.

In 2020, the Council of the European Union approved new taxation rules increasing the threshold for an excise reduction for lower strength beers to 3.5% abv from the previous 2.8% abv, noting that this measure can provide incentives for consumers to choose low-strength alcoholic drinks over stronger ones, thereby reducing alcohol intake.

By its nature, beer already has a low concentration of alcohol. Yet an imbalance exists, as beer is heavily taxed - in Canada taxes are nearly 50% of the price of beer – and beer is more expensive than higher concentrated alcohol products.

A smart alcohol policy which has as its objective the reduction of harmful alcohol use, does not price lower alcohol content drinks out of people's reach and does not favour higher alcohol products over lower alcohol products (L. Bershidsky, Bloomberg Opinion, 2019).

Researchers (Rehm, J. & Hasan O. Alcohol, 2020) note that in the Russian Federation, "the shift from spirits to beer over the past years seems to have been accompanied by an overall positive effect on alcohol-attributable harm". Similarly, Kueng, L. and Yakovlev, E. (Research Paper, 2020), having studied the impact of alcohol control policies on mortality rates and consumer preferences in Russia, conclude that the policy environment created greater availability and affordability of beer relative to high-alcohol-strength licit and illicit distilled products, prompting a cohort of consumers to adopt lasting preferences for lower-strength alcohol.

With respect to data, reconfiguration should be considered for comparative risk assessments as appropriate – like the Global Burden of Disease or the WHO Global Status Report – to factor in the differential impacts of beverage types (Rehm, J. & Hasan, Alcohol, 2020). In addition, as another priority, statistical agencies should be encouraged to invest in being able to more accurately capture alcohol by volume. Currently, agencies track for the most part with assumptions on the average strength within each beverage alcohol type, which impact calculations of absolute alcohol consumption. This should be improved to get a more accurate picture of actual figures.

The evidence base together with common regulatory practices demonstrate that enabling greater promotion of products with a lower concentration of alcohol can be an effective option in reducing harmful alcohol use and alcohol-related harm. A policy approach which shifts consumption from higher alcohol products to lower alcohol products is entirely consistent with the Global Strategy, which recognizes that "[h]arm reduction approach can be supported by stronger promotion of products with a lower alcohol concentration". These measures should be supported and recommended by the Working Document and integrated into any subsequent Global Strategy Action Plan.

CONCLUSION

An action plan which fully aligns with the Global Strategy will be more successful than one that does not, given the progress already made in reducing harmful alcohol use and alcohol-related harm under that Strategy. By excluding industry from key areas of engagement and discussions, the Working Document invalidates core principles of the Global Strategy and the 2018 UN Political Declaration on Non-Communicable Diseases, undermining the shared objective of reducing the harmful use of alcohol. Consistent with the Global Strategy, the Working Document should recognize and recommend policy options that expand the adoption of low and no-alcohol products, including a policy mix that differentiates between higher alcohol and lower alcohol content beverage alcohol types.

Beer Canada welcomes the opportunity to contribute to the consultation on the Working Document and a future Global Strategy Action Plan, and we hope that our comments and recommendations will be helpful to this process.

Regards,

A handwritten signature in black ink, appearing to read "Luke Chapman".

Luke Chapman
Interim President
Beer Canada

Belgian Brewers

Country/Location: Belgium

Submission

The Working Document argues that there is an inherent conflict between the interests of the alcohol industry and the interests of public health. This presumed conflict is used to justify excluding the industry from all discussions on public health policy and demand that the industry refrain from funding public health policy-related research. As a national federation, we feel we can have an added value in the discussion and we do not believe there is an inherent conflict of interest between the brewers' interests and those of public health. Therefore there is no justification to de facto exclude brewers from public policy discussions.

On the issue of differentiation, all European countries, in one manner/policy or another, treat different alcoholic beverages differently, whether it be through the fiscal system, the rules on access to alcohol or the places and times where marketing is permitted.

More details on our point of view can be found in the position paper attached.

Attachment(s): 1

00403_52_201207-positionpaper-who.pdf

Position paper by the Belgian Brewers regarding “Developing a Global action plan to reduce the harmful use of alcohol” – web based consultation

Inclusion:

The Working Document argues that there is an inherent conflict between the interests of the alcohol industry and the interests of public health. This presumed conflict is used to justify excluding the industry from all discussions on public health policy and demand that the industry refrain from funding public health policy-related research.

- Brewers are highly local and heavily embedded in the socio-economic health of the communities where they are located. Belgian Brewers also has an important insight in the decision-making process of the different Belgian governments and truly believes that a pan-sectoral platform (including academia, public health, NGO’s and industry) is the only way to tackle alcohol abuse. Such a platform also subscribes the “whole of society” approach championed by the WHO and its leadership.
- Belgian Brewers does not believe there is an inherent conflict of interest between the brewers’ interests and those of public health. Therefore there is no justification to de facto exclude brewers from public policy discussions.
- The Belgian brewers have invested heavily in the development and adoption of low- and no-alcohol beers. These innovations are responsive to consumer demand for lower alcohol products, offering responsible consumer choice in situations where alcohol consumption is either inadvisable (for exemple when driving, pregnant, etc..) or when a consumer simply wishes to consume beer but also to consume less alcohol. Non- and low-alcohol innovations are aligned with public health objectives on reducing the harmful consumption of alcohol. Our statistics show that low- and no-alcohol beers are gaining year by year more market share. Furthermore, we notice that ordering or buying low- and no-alcohol beers is no longer a taboo.
- Collaboration is critical for creating “win-win” situations like the expansion of low- and no-alcohol products. Reflecting on the potential of the brewers’ ability to reduce alcohol content without changing the quality of beer, [Jurgen Rehm](#) found that **“reduction of alcoholic strength might constitute a unique situation, whereby the interests of public health (in reducing overall consumption of alcohol) and the alcohol industry (in achieving profit) coincide.”**
- In the absence of a legal obligation set in EU law, the brewing sector voluntarily committed to roll out ingredients and calorie labelling. The brewing sector is voluntarily doing so in exactly the same manner in which nonalcoholic beverages and foods are legally obliged to do so. The Brewers leadership on labelling is a clear sign of their engagement to social responsibility by signing the MoU (Memorandum of Understanding) with the European Commission. Belgian Brewers also subscribed this MoU in which the ambition is to ensure that all pre-packed beer containers carry this information in 2022.
- Since 1995, the Federation of the Belgian Brewers, as co-founder and partner, actively and financially supports the BOB-campaign, an awareness campaign led by the VIAS Institute (ex-BRSI, Belgian Road Safety Institute) to reduce the number of road accident

Bier met liefde gebrouwen, drink je met verstand

victims as a result of alcohol abuse in traffic. The principle is known: BOB is a designated driver who commits himself to drinking no alcohol and staying sober so that he/she can drive his/her friends safely back home. With the endorsement of the BIVV and Belgian Brewers the designated driving became a national movement, with "designated driver" becoming a common phrase. The BOB-campaign is aimed at everyone and has already yielded excellent results. Several polls have indicated a graduated increase in designated driving practices and since the start of the initiative, the campaign is credited as a contributing factor to the decline in alcohol-related traffic fatalities. The "Bob" campaign was an instant hit, changing people's attitudes toward drinking and driving. The campaign is so successful that it was replicated in 16 other European countries with support from the European Commission. The Belgian Brewers has played a pioneering role in this campaign. The support to the BOB-campaign fits in perfectly with the federation's will to promote initiatives and campaigns to inform consumers of the benefits of moderate beer consumption and the risk of alcohol abuse.

- The consumption of beer in Belgium has been declining since more than 15 years. Statistics show that consumers drink less beer whether it is at home or in the horeca.

Differentiation:

All European countries, in one manner/policy or another, treat different alcoholic beverages differently, whether it be through the fiscal system, the rules on access to alcohol or the places and times where marketing is permitted. The Working Document is a missed opportunity to reflect this reality and act on the evidence that alcohol policies in the areas of taxation, availability, and marketing can be adjusted to nudge consumers toward lower-alcohol-strength beverages, significantly reducing alcohol-related harms.

The evidence shows that:

- The effects of alcohol consumption depend on what you drink and how you drink it. Research and testimonials show that for example binge-drinking is rarely done with beer, but most often with hard liquor. Therefore Belgian Brewers believes that a differentiation is recommendable since rapid consumption of highly concentrated alcohol, for example, carries a higher risk for certain harms.
- Using policy levers to nudge consumers toward lower-alcohol-strength products can significantly reduce alcohol-related harm while also creating incentives for producers to create lower-alcohol-strength products.
- Numerous alcohol policy experts have called for more widespread implementation of this approach.

Covid-19 crisis – beer disproportionately impacted

Finally, the current COVID-19 crisis has also constituted an interesting experiment into the impact of certain alcohol policies, showing that legislation has the potential to impact in different ways the consumption of different alcoholic beverages:

- In Belgium the crisis has not led to increased per capita beer consumption, which has been specifically and particularly impacted by the closures of the hospitality sector.
- In Belgium, beer is typically consumed in social settings and the full or partial closure of these regulated bar and restaurant environments, combined with further restrictions on social interactions in other, also private settings, has meant that the drops in hospitality beer sales (45 % of the beer market) have not been matched at all by equivalent increases in beer sales from the retail sector (+ 0,4 %).
- The EU beer market is forecast to have declined by up to 20% in 2020, meaning a major drop in the consumption of lower alcohol beverages, due entirely to the closure of the hospitality sector.
- Supporting the recovery of the hospitality sector as a safe and regulated environment will support the nudging of consumers towards lower-alcohol-strength beverages.

Nathalie Poissonnier
Directeur Belgische Brouwers

Lambert De Wijngaert
Secretaris-Generaal Belgische Brouwers

Bendukidze Free Market Center

Country/Location: Ukraine

Submission

WHO's Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol has revealed a deeply worrying shift of focus from harmful use of alcohol to consumption in general.

While taking into account the fact that harmful use of alcohol causes approximately 3 million deaths every year, it is important to separate measures aimed at alcohol-related harm reduction from the prohibitionist ones. This new underhanded approach of basically equating any alcohol use to tobacco use is a leap that should not go unopposed. Moreover, a lot more research of alcohol use and abuse should be carried out, especially concerning unrecorded and illicit alcohol, the use of which will increase if formal alcohol is severely restrained, as it is suggested.

Attachment(s): 1

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Summary

WHO's Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol has revealed a deeply worrying shift of focus from harmful use of alcohol to consumption in general.

While taking into account the fact that harmful use of alcohol causes approximately 3 million deaths every year, it is important to separate measures aimed at alcohol-related harm reduction from the prohibitionist ones. This new underhanded approach of basically equating any alcohol use to tobacco use is a leap that should not go unopposed. Moreover, a lot more research of alcohol use and abuse should be carried out, especially concerning unrecorded and illicit alcohol, the use of which will increase if formal alcohol is severely restrained, as it is suggested.

Management of substance abuse or use?

I find it highly ironic that I am putting finishing touches to this consultation response on a day that saw the end of alcohol prohibition in the US in 1933. The issue of alcohol abuse or harmful use of alcohol without any doubt belongs at the top of a health priority list. According to a WHO report, more than 3 million people died as a result of harmful use of alcohol in 2016. Thus, it absolutely makes sense that an organization like WHO would be working on a global strategy to reduce the harmful use of alcohol. However, it is important to distinguish between harmful use and use in general.

While citing available statistics and data, most researchers point out that most harm associated with alcohol stems from excessive consumption. It causes not only health problems for drinkers themselves, but people around them as well. "Alcohol consumption, particularly heavier drinking, is an important risk factor for many health problems and, thus, is a major contributor to the global burden of disease. In fact, alcohol is a necessary underlying cause for more than 30 conditions and a contributing factor to many more. The most common disease categories that are entirely or partly caused by alcohol consumption include infectious diseases, cancer, diabetes, neuropsychiatric diseases (including alcohol use disorders), cardiovascular disease, liver and pancreas disease, and unintentional and intentional injury" (Rehm 2011).

Thus, when approaching this issue it is necessary to draw the line between alcohol use and abuse. Hazardous and harmful drinkers only constitute a minority of those who drink; in England they comprised 24% of the adult population in 2007 (Martin-Moreno et

al 2013). Which is exactly why it is surprising to see that one of the targets that WHO is proposing is a later-to-be-determined percentage of per capita alcohol consumption reduction. It becomes even more surprising when taking into account the fact that in 2016 the total alcohol per capita consumption was 6.4 liters, which is about the same as in 2010, and the percentage of current drinkers in the world was generally 4.6% lower than in 2000 (Iranpour et al 2019).

Instead jumping the gun and targeting general alcohol use, substantially more research should be done on the issue. Since there is a tendency to compare alcohol and tobacco, the amount of data available on the latter is almost twice as high. In order to have a clear picture and develop evidence-based policies, we need to have a much better understanding of patterns of alcohol consumption (like binge drinking, heavy episodic drinking), their change over a lifetime, amounts of illicit alcohol production and consumption, not just amounts, but also alcohol quality, etc. Without carefully considering these factors, it is difficult to determine and measure alcohol-related harm objectively.

Moreover, there is lack of research on the causal effect of alcohol price increase on the consumption of illicit alcohol, which is extremely dangerous. Based on historic evidence, strict regulation tends to force people to substitute formal and higher-quality alcohol with homemade or surrogate. Its 'market' share is already quite substantial, 25.5% of the alcohol consumed globally is ingested illicitly or without proper supervision (Iranpour et al 2019). Therefore, it should be taken into consideration when weighing costs and benefits of proposed measures.

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Blue Cross Kisumu - Kenya

Country/Location: Kenya

URL: www.bluecrosskisumu.org

Submission

1. We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.
2. We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.
3. We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol issues. We further propose to remove two other points in the list of challenges (see detailed description below).
4. The absence of a global, legally binding instrument, leading – among other things – to a lack of protection from alcohol industry interference, is the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).
5. Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.

Attachment(s): 1

00237_39_action-plan-consultation-dec2020.pdf

Submission from Blue Cross Kisumu - Kenya

WHO Web based consultation 16 November – 13 December 2020

Working Document to develop an action plan for improving WHO global alcohol strategy implementation

We are grateful for the opportunity to comment on the working document and appreciate the effort by WHO in conducting an ambitious consultative process. We have reviewed the document and have the following comments and suggestions for your consideration.

Blue Cross Kisumu is a Non-governmental organization that works with Children, Youth and families affected by alcohol use. We have developed together with non-state actors policies and by laws on alcohol free schools, Life Skills Education manuals and hands on interventions within the communities and trained Peer leaders who carry out alcohol harm campaigns in schools and with out of school youth. We are currently engaging with the members of county assemblies to revise the alcoholic drinks control act to give more power to the act on enforcement.

In our submission we will first outline a few key points, then we go on to give more detailed comments and proposals on the different parts of the working document.

Thank you for your consideration.

Yours sincerely,

Ishmael Shem

Director,

Blue Cross Kisumu - Kenya

Key comments

1. **We strongly disagree with the role assigned to the alcohol industry** in the working document, especially in the key areas for global action. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.
2. **We propose bold, ambitious overall targets** of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.
3. **We caution against the description of alcohol harm as “complex” problem** because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol issues. We further propose to remove two other points in the list of challenges (see detailed description below).
4. **The absence of a global, legally binding instrument**, leading – among other things – to a lack of protection from alcohol industry interference, is the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).
5. **Associated to alcohol use are not “only” the health and social harms**, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.

Detailed comments on the working document

In general, we welcome and support large parts of the working document as elements of the future action plan.

Regarding Setting the scene

We support the focus on strengthening global action, building on the mandate that Member States have given WHO in 2010 and that Member States have renewed with the WHO governing body decisions in 2019 and 2020.

Concretely, we welcome and support the effort to define clear targets and indicators.

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan. We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan (see below).

We welcome and support the analysis of and emphasis on the potential of mainstreaming alcohol policy into other relevant policy sectors and to promote cross-sectorial work to advance alcohol policy development.

Fourthly, we welcome and support the emphasis on alcohol's role across the GPW13's triple billion target. This shows what the potential of this new alcohol action plan could be: to strengthen the mandate and case for global action on the entirety of alcohol harm – in this way unlocking the full potential of alcohol policy solutions.

Proposing a bold overarching target

While we welcome and support the global action area targets and the indicators listed in Annex I, we miss one overarching target that underpins the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries.

Placing SAFER front and center

The setting the scene section can be improved by placing the SAFER alcohol policy blueprint front and center. The case for action and the return on investment should be made clear from the

outset: Implementation of the three best buys would result in a return on investment of \$9 for every \$1 invested. Already in 2010, the WHO Global Health Report outlined that:

“Raising taxes on alcohol to 40% of the retail price could have an even bigger impact [than a 50% increase in tobacco taxation]. Estimates for 12 low-income countries show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries “

This locates the alcohol action immediately within wider efforts to achieve universal health coverage and to reach the SDGs.

Regarding the WHO GAS implementation

We support the analysis of the last ten years of WHO GAS implementation around the world.

While we do not disagree with the presentation of the evidence, we ask for stronger conclusions and clearer messages regarding the evaluation of the decade of WHO GAS implementation in this section.

WHO GAS implementation over the last ten years has been ineffective, inadequate and outdated. Some of the evidence should be presented to set the scene for the action plan.

- Alcohol availability regulation remains inadequate, according to findings from the WHO Global Alcohol Status 2018, to compound the situation, alcohol is actually becoming more widely and easily available. The number of licenses to produce, distribute and sell alcohol – a marker for increased rather than decreased availability – is increasing in much of the world, particularly in lower-income countries.
- Levels of treatment coverage vary substantially across countries but are inadequate across the world. Only 14% of reporting countries indicated high treatment coverage, and 28% of reporting countries indicated very limited or close to zero treatment coverage.
- Alcohol marketing regulations remain inadequate, too. Digital alcohol marketing restrictions are far behind technological innovation in the alcohol industry. 28% of countries had no regulations on any media type in 2016, most of them being located in the African or Americas regions.
- While 95% of all reporting countries implement alcohol excise taxes, fewer than half use the other price strategies highlighted in the WHO GAS – such as adjusting taxes to keep up with inflation and income levels, imposing minimum pricing policies, or banning below-cost selling or volume discounts. This shows that alcohol pricing policies remain inadequate. For example, in 2017 only 59% of responding countries had implemented a tax increase on alcoholic beverages since the adoption of the WHO GAS. Only a third of countries adjust those taxes regularly for inflation, and eight countries (five of them in the WHO European Region) reported increasing their subsidies for alcohol production.

It is important that this analysis is added to the chapter about WHO GAS implementation. It is an understatement to conclude that implementation has been “uneven”. The evidence shows that

the majority of countries falls short of adequately responding to the alcohol burden with the most cost-effective and impactful alcohol policy solutions.

Protecting children, youth and adults who don't use alcohol

We welcome and support the discussion of the alcohol abstaining population in the world. Protecting children, youth and adults from pressures to start consuming alcohol and in their non-consuming behaviour is a guiding principle of the WHO GAS.

Regarding WHO GAS implementation challenges

We welcome and support the analysis of the challenges that WHO GAS implementation was faced with over the last decade. We note that WHO examines 15 challenges.

The reason why this section is so important is that it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective, inadequate and outdated.

We propose to remove three items from the description of the challenges for WHO GAS implementation: Number one, two and three.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol (health) issues.

Secondly, while there might be differences between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention are equally able to take political action to reduce their alcohol burden.

Thirdly, we understand that intersectoral approaches to societal problems are not easy, but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

A more systematic order of implementation challenges

Not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power

3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

Protection against alcohol industry interference

Alcohol remains the only psychoactive substance that is not under any binding international control regime, despite its massive global burden. Therefore, protections against alcohol industry interference are missing and pose the biggest challenge to WHO GAS implementation.

The alcohol industry deploys its political, market and purchase power to interfere in public health policymaking in order to delay, derail and destroy alcohol policy-making efforts. They also leverage aggressive marketing spending, for example in the digital world – as the coronavirus crisis has brought into sharp focus, and they deploy corporate social responsibility schemes to white-wash their image, cultivate relationships and avoid statutory public health policies.

We urge for such a description to be added to the next document. Ten years of evidence from attempts to implement the WHO GAS have contributed compelling evidence.

Regarding WHO GAS implementation opportunities

We welcome and support the analysis of the opportunities for preventing and reducing alcohol harm; but the section should be better framed as opportunities to accelerate action on WHO GAS implementation (as are the challenges) – as called for by Member States.

We agree with all the opportunities outlined in the working document. The reason why this section is so important is that it provides context for global and national action to capitalize on these opportunities.

Regarding Scope of the action plan

We welcome and support the scope of the action plan to comprise concrete action and significant improvements to the global governance of alcohol policy development. Importantly, we welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

We support and welcome the actions suggested for Member States and the WHO. Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. But we support the ambition, quantity and quality of the actions outlined because it signifies Member States' obligation to ensure their citizens are protected from alcohol harm. The proposed actions also illustrate that it is WHO's responsibility to live up to the strong mandate it has received in 2010 and on different occasions since then.

All stakeholders are not equal

In this context, we must highlight that all stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm. There is a fundamental conflict of interest on part of the alcohol industry.

Clearly, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world (see above). Therefore, we make concrete suggestions for how the role of different stakeholders can be better reflected in the action plan.

Regarding Goal of the action plan

We welcome and support the reiteration of the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We suggest including the health, social, economic and sustainable development consequences of alcohol but we fully endorse this overarching goal.

What we want to improve

There needs to be a section/ chapter dealing with the vision, mission and targets of the action plan. Goals and implementation could be kept separate for purpose of clarity.

Commenting on the formulation of the goal: Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences of alcohol in the description of the goal.

Regarding Proposed operational objectives

We welcome and strongly support the action-oriented nature of the working document’s outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions.

In support of the operational objectives, we propose a logical model, and we propose adding two more operational objectives that have gone missing from the WHO GAS’ objectives.

What we want to add

We propose to add two more operational objectives. Our analysis of the working document and the WHO GAS has shown that some elements of the original objectives went missing. While we support the operational objectives as suggested in the working document, we are convinced that the following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Objective 8 builds on missing elements contained in WHO GAS objective 4.

Regarding proposed key areas for global action

Broadly, we welcome and support the set of 6 key areas for global action, including the quantity and quality of the actions detailed. Some elements can be improved, some elements are missing, and some elements should be reworked while some others should be removed – as outlined in Movendi International's submission, which we endorse.

We propose to reframe and rework the key areas for global action as “framework for action”, as for example the WHO Global Action Plan for Physical Activity (GAPPA) does. This allows to streamline the actions and create greater coherence across the action areas.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO. Therefore, we propose to include civil society and international partner action in a separate section and to focus Member States and WHO action in the “Framework for action”.

Global action on reporting about alcohol consumption, related harm and policy development should reflect the magnitude and urgency of addressing the alcohol burden. In tobacco control, a global report is launched every year. For alcohol prevention and control that should be the ambition, too.

Role of the alcohol industry

We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. The working document remains incoherent, as is the WHO GAS.

It is critical that the action plan overcomes this incoherence within the frames of the mandate given by Member States through the WHO GAS but in line with a decade of evidence about the alcohol industry's role in delaying, derailing and destroying attempts to implement the WHO GAS.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Regarding improvements to the global governance and infrastructure for alcohol policy development

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitating leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. The reasons are clear and have indirectly addressed in the working document. Therefore, we are convinced that the action plan benefits from including a section about infrastructure and governance improvements – applying lessons learned from other health areas.

Examples of such infrastructure on the level of global action could be:

- A global ministerial conference on alcohol under the guidance of WHO
- A Global Fund for Alcohol Prevention
- A global initiative to advance alcohol taxation
- A functioning international network of alcohol focal points, like there is for NCDs government focal points
- A mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals
- Civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues
- A specific WHO program on alcohol to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called "Infrastructure".

Brazilian Institute of Cachaça - IBRAC

Country/Location: Brazil

Submission

The Brazilian Institute of Cachaça (“IBRAC”) would like to thank the World Health Organization for providing the opportunity to comment the public consultation regarding the WHO’s ‘Working Document for the Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol’.

The first point that IBRAC aims to address is related to the menu of policy options included in the Global Strategy. IBRAC understands that the action plan must recognize the comprehensive package of policy options and interventions included in the Global Strategy as an effective menu of measures for reducing the harmful use of alcohol.

The second point that IBRAC would like to address through this document is that the COVID-19 pandemic deepened the crisis in the Cachaça sector. The closing of bars and restaurants, cancellation of events, and less personal income available for consumption have severely affected the whole Industry. Sales in the beverage sector fell 71% in the first two weeks of April (71%) ; 20% of the bars and restaurants in Brazil have closed down ; 65% of Cachaça producers saw a reduction of more than 50% in sales ; one million is the estimated number of layoffs in bars and restaurants which are the main channels for selling Cachaça. According to a EUROMONITOR International estimate, the sector of Cachaça should experience a decline of over 20% in 2020 as a result of impacts produced by the COVID crisis.

Attachment(s): 1

00427_62_comments-ibrac-who-working-plan-final.pdf



FOR ELECTRONIC SUBMISSION

Brasília, December 13, 2020.

To the World Health Organization

Subject: Response to the public consultation regarding the WHO's 'Working Document for the Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol'

To Whom it May Concern:

1. The Brazilian Institute of Cachaça ("IBRAC") would like to thank the World Health Organization for providing the opportunity to comment **the public consultation regarding the WHO's 'Working Document for the Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol'**.
2. These comments are submitted within the deadline set forth in the notification and contain no confidential business information.
3. **IBRAC** is a trade organization that represents the sector of Cachaça and our role is to advance the interests and profile of CACHAÇA (an exclusively Brazilian sugar-cane spirit and a Geographical Indication pertaining to Brazil), our members and of the Brazilian industry as a whole in Brazil and globally.
4. Having examined the public consultation, **IBRAC** understands that it is important and opportune to submit comments for the WHO's 'Working Document for the Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol' through this official letter.
5. The first point that IBRAC aims to address is related to the menu of policy options included in the Global Strategy. IBRAC understands that the action plan must recognize the comprehensive package of policy options and interventions included in the Global Strategy as an effective menu of measures for reducing the harmful use of alcohol.

Brazilian Institute of Cachaça - IBRAC
SRTVN Quadra 701 Conj. C Nº. 124 Sala 603 Ala A
CEP: 70719-903 - Brasília-DF - Brasil
Tel.: +55 61 3326-0747 - Fax: +55 61 3328-5271
ibrac@ibrac.net - www.ibrac.net



6. In 2015, a measure instituted by the Brazilian Government increased taxation levied upon Cachaça which was already one of the most highly taxed products in Brazil. The measure changed the system of application of the Industrialized Products Tax (*Imposto sobre Produto Industrializado* – IPI) applied to the beverage, and a rate of 25% *ad valorem* was established for Cachaça. The impact of the measure, upon a number of products, was an increase of over 200% on the tax paid alone (not to mention the other taxes that are counted), as stated in a manifest released by the sector in 2018.

7. This Brazilian Government’s measure generated severe unintended consequences, such as an increase of competitive inequality and growth in the ‘illegal’ (i.e., illicit) market.

8. One can see this increase in competitive inequality when one compares market share with the share participation of each category in the collection of IPI tax. Spirits overall (including Cachaça), that have IPI rates between 25% and 30% account for **10%** of the market share and **34%** of the IPI collected from the entire alcoholic beverage industry. On the other hand, beer for example represents **87%** of the total beverage alcohol market, but accounts for only **55%** of the federal collection of IPI tax in this sector¹.

9. It is important to highlight that in the same year (2015) the Federal Government reduced the rate of IPI on beer from **15%** to **6%**. This rate is lower than relatively more essential goods, such as foods, in which biscuits and cookies stand out at a 10% rate; hygiene and beauty products - with shampoos and deodorants taxed at 7%; and infrastructure items - such as bricks, upon which the rate of IPI is 8%.

10. The identification of this disproportionality and the clear contradiction as regards the legal nature of the tax on industrialized products is even more contradictory when one considers that, in Brazil, consumers who are light, moderate or abusive ‘users’ consume beer, which represents 87% of total alcoholic beverage consumption in the country by volume, as mentioned above.

11. Furthermore, greater taxation does not result in effective improvements in health as it does not reduce harmful alcohol consumption. The working document proposes a target for increasing the number of countries that have earmarked tax revenue for reducing the harmful use of alcohol. This is despite previous WHO documents stating that there is an “active debate over the potential advantages

¹ LCA Consulting (Market Size Research, June/2019) and the Brazilian Central Bank.



and disadvantages of earmarking revenues and contributions”², citing inefficiency and distortions in the economy as disadvantages of this approach.

12. Abusive consumers are least responsive to tax policies for price increase, especially in a country like Brazil with a huge inequality in personal income. This kind of consumer in Brazil, as a low-income country where an illicit product is 70% cheaper than a legal product³ finds ‘unrecorded’ alcohol their sole option to continue their harmful consumption. Definitely, it does not attack the problem⁴. To the contrary, it also stimulates the illicit alcoholic beverage market.

13. According to the Euromonitor Illicit Alcohol Study from 2018 (2017 data), illicit beverages represent 28.8% of the spirits market in Brazil. Organized crime profited R\$3 billion that year. Government lost R\$5.5 billion in 2017 alone in tax evasion. In addition, the sector of Cachaça is inclined to think that this fiscal loss will be higher than it was in 2017 at the end of 2020 because of the illicit spirits market reaching 37.9% in share, with an increase of 10.1% in comparison to 2019 due to the COVID-19 pandemic, according to Euromonitor’s new study⁵.

14. The impact on the Cachaça sector clearly reflects this unintended consequence of a high tax burden compounded by competitive inequality. The illicit market, in number of Cachaça producers, reaches 90%. Registered producers dropped 22.26% in 2019, from 1,397 in 2018 to 1,086 in the following year, according to Ministry of Agriculture data. An IBRAC estimate, based on data from 2018, indicates that the market for Cachaça is approximately 632 million liters of which 112 million liters are illicit.

15. Illegally produced beverages do not follow sanitation regulations, so they pose serious risks to people's health.

16. The current scenario of illegal market and competitive inequality requires tax isonomy and not the creation of new taxes and the increase of tax burdens, which would produce the opposite result: it would have little impact on harmful consumption and would also benefit the illicit market.

17. All things considered, an action plan must recognize a comprehensive package of policy

² World Health Organization, Arguments for and against earmarking.

³ Euromonitor Illicit Alcohol Study from 2018 (2017 data)

⁴ Vieira, B.A., et al., Timing and Type of Alcohol Consumption and the Metabolic Syndrome - ELSA-Brazil. PLoS One, 2016. 11(9): p. e0163044

⁵ Illicit Alcohol in LATAM – COVID-19 – Impact Model, Euromonitor, 2020



options and interventions included in the Global Strategy as an effective menu of measures for reducing the harmful use of alcohol, considering that assessment of local contexts is required to analyze each context not only in terms of pattern of alcohol consumption, but also of the structure of the market in terms of competition, the legal framework and illicit market scenario. Recommendations on taxation should be consistent with the Global Strategy which calls for efficient taxation and recognizes the impact of the illicit market. The Global Strategy suggests member states give regard to “regulating sales of informally produced alcohol and bringing it into the taxation system” as part of an efficient taxation system.

18. So, the use of SAFER or inclusion of actions that prioritize the implementation of SAFER over other possible interventions is limited and could create, if applied alone, unintended consequences that would require more public investment and other public policies to deal with this.

19. The second point that IBRAC would like to address through this document is that the COVID-19 pandemic deepened the crisis in the Cachaça sector. The closing of bars and restaurants, cancellation of events, and less personal income available for consumption have severely affected the whole Industry. Sales in the beverage sector fell 71% in the first two weeks of April (71%)⁶; 20% of the bars and restaurants in Brazil have closed down⁷; 65% of Cachaça producers saw a reduction of more than 50% in sales⁸; one million is the estimated number of layoffs in bars and restaurants⁹ which are the main channels for selling Cachaça. According to a EUROMONITOR International estimate, the sector of Cachaça should experience a decline of over 20% in 2020 as a result of impacts produced by the COVID crisis.

20. Even under this scenario, the Cachaça sector contributed to combatting the spread of COVID-19 in Brazil. Producers of Cachaça were responsible for the production and donation of over 150,000 liters of 70% alcohol. This demonstrates the effectiveness of a ‘whole-of-society’ approach during the pandemic in order to protect health.

⁶ “Revenue from alcoholic beverage companies drops 71% in the first half of April,” published by Infomoney on April 20, 2020.

⁷ “Bars and restaurants fire 1 million and 20% of the businesses close down,” published by the R7 news web site on May 12, 2020.

⁸ Data from IBRAC - Brazilian Institute of Cachaça – Internal research among members

⁹ “Bars and restaurants fire 1 million and 20% of the businesses close down,” published by the R7 news web site on May 12, 2020.



21. In addition to that, IBRAC in collaboration with other trade associations representative of the alcoholic beverage sector in Brazil has run a public campaign in order to prevent harmful use of alcohol during the period of required isolation/quarantine. The campaign involves periodic posts on social media and networks to guide consumers in the responsible use of alcoholic beverages.
22. Not only during the isolation period but also in previous years and until the present day, IBRAC has taken part in a public campaign called *Maio Amarelo* (Yellow May) in which one of the aims was to educate drivers in “don’t drink and drive”.
23. Organized by the *Observatório Nacional de Segurança Viária* (National Road Safety Observatory), the objective of the Maio Amarelo movement is a coordinated action between the powers of government and civil society. The intention is to put the topic of road safety on the agenda and mobilize the whole of society, involving the most diverse segments, such as: government agencies, companies, representative entities, associations, federations and organized civil society to effectively discuss the issue of road safety, in its various aspects, engaging in actions and disseminating knowledge while addressing the full scope that the issue of traffic requires, in all of the various spheres.
24. This campaign is one that has contributed most strongly to the success of the policies against drunk-driving. After consecutive increases, the number of individuals who consumed alcohol and drove had a slight decrease between 2016 and 2017. The number of people to resort to the public health system as a result of motor-vehicle accidents involving the consumption of alcohol also dropped by 4%. After ten years since the approval of the “Lei Seca” (i.e., the law against drinking and driving), the number of deaths due to traffic accidents fell by 2.4%. It then fell about 16% when compared to the first amendment to the law in 2012, which made punishment more severe for those who drink and drive. In the end, 41 thousand deaths were avoided in 10 years of the “Lei Seca”.¹⁰
25. This is evidence of how the sector of Cachaça has supported work in reducing drunk driving. So, the third point IBRAC wishes to make is the importance of fully incorporating ‘economic operators’ within a whole-of-society approach to reducing the harmful use of alcohol at all levels: national, regional, and global, in the action plan.

¹⁰ Prospectiva based on Vigitel from 2012 to 2018



26. Thus, based on the evidences of tandem work between private and public sectors towards policies and campaigns in the “don’t drink and drive” arena, it is important to point out (fourth point) that the action plan must remain singularly focused on the reduction in the “harmful use of alcohol” and avoid any recommendations that focus on a reduction in “consumption *per se*” as these would be inconsistent with the objectives of the Global Strategy, and the remit of WHO’s work on alcohol, as agreed by member states in order to be consistent with the Global Strategy and the UN Political Declaration (UNPD).

27. Aside from that, IBRAC has implemented a campaign whose slogan is “Alcohol is Alcohol” in order to disseminate the concept of “standard” drinking.

28. In Brazil, there is a misperception that “cold drinks”, usually represented by beer, are less harmful and less “alcoholic” than “hot drinks”, among which spirits like Cachaça would be included. In reality, all alcoholic beverages contain the same molecule: ethanol.

29. Considering that 30ml of Cachaça or other spirits (ABV 40%), 100 ml of wine (ABV 12%) and 330 ml of beer (ABV 4%), on average, have the same amount of ethanol, that is about 10 grams, the idea is to educate consumers to start thinking in terms of grams of alcohol in a glass or cup so that consumers can better assess how much they drank or will drink. The correct definition ensures transparency of communication.

30. This campaign has two objectives. One is to address the necessity of a parameter of moderation in Brazil in order to reduce the harmful use of alcohol that nowadays has been highly promoted by social media ‘fake news’ that beer is less alcoholic than spirits.

31. The other objective is to address and point out the competitive inequality to government authorities. The misperception described above has led the government to issue laws that treat alcohol in a different manner, not only making the tax law but also the law on advertisement and self-regulation promoters of inequality.

32. By correcting this inequality on the front of advertisement, Brazilian authorities would take a step forward in reducing the exposure of minors to advertising for, that way, all beverages will be subject to the same restrictions in terms of advertising on TV and radio. Since the early 1990’s, beer has been allowed to advertise throughout the entire day.



33. This is an example of the importance of economic operators joining in efforts to combat the harmful use of alcohol. Through the effective use of its unique expertise, insights, and resources, and through support for co-regulatory systems, the private sector can make a positive contribution to reducing the harmful use of alcohol.

34. Therefore, to be consistent with the Global Strategy and the 2018 UNPD, IBRAC understands (fifth point) that the working document should acknowledge the importance of economic operators acting together with other actors in efforts towards the reduction of harmful use of alcohol and not portray economic operators as a barrier to progress.

35. Lastly, IBRAC reinforces its commitment to combat the harmful use of alcohol in Brazil in partnership with government, policy makers and society, cooperating in the creation of an environment that protects minors, without competitive inequality and with lower levels of illegality/illicitness.

36. IBRAC gratefully appreciates if the above mentioned comments / petition could be taken into account.

37. Please do not hesitate to contact us if you need any additional information to support this submission.

Respectfully submitted,

Carlos Lima
Executive Director
Brazilian Institute of Cachaça

Brazilian National Beer Chamber – Ministry of Agriculture, Livestock and Supply

Country/Location: Brazil

Submission

The Brazilian National Beer Chamber represents the whole supply chain enrolled with beer production: agriculture raw material suppliers, packaging suppliers, beer industry major producers, small and medium beer producers, the government representatives and technical advisers, and is established within the Brazilian Ministry of Agriculture, Livestock and Supply structure.

In Brazil, beer represents a sector that contributes approximately R\$ 25 billion in tax generation per year (2% of national GDP) and employs 2.7 million persons, including direct, indirect and induced employees. Understanding the beer sector relevance for the country sustainable development, the Brazilian Beer Chamber welcomes this opportunity to contribute with the Working document for development of an action plan to strengthen implementation of the “Global Strategy to Reduce the Harmful Use of Alcohol”.

We declare our support to the initiative to expand and improve the “Global Strategy to reduce the harmful use of alcohol” and we understand that the terms approved and preconized by the WHO Executive Board (EB) must be followed:

“development an action plan (2022-2030) to effectively implement the Global strategy to reduce the harmful use of alcohol as a public health priority, in consultation with Member States and relevant stakeholders, for consideration by the 75th World Health Assembly through the 150th session of the WHO Executive Board in 2022” (decision EB146 (14))”.

In this sense, the structure of the Global Strategy and the relevant improvements stated on the 2018 UN Political Declaration (UNPD) on non-communicable diseases, must be followed. What includes the enrollment of the economic operator, as well as all society levels, and the Global Strategy (2010) policies set.

10 years of Global Strategy: the Brazilian advances

It is essential to highlight that Brazil has shown positive results towards the goal of a 10% reduction of harmful alcohol consumption by 2025. Data from the WHO Global Alcohol and Health Report 2018 indicate that 40% of the population consumed alcohol. There was an 11% reduction in per capita alcohol consumption in the country - from 8.8 liters (L) in 2010 to 7, 8 L, in 2016. In addition, during this same period, there was a reduction in the rate of alcohol use disorders (from 5.6% to 4.2%, well below the average in the Americas region - 8.2%).

The implementation of the Dry Law (Law No. 11,705 / 2008), and Law No. 13,106 / 2015, which made it a crime to offer alcohol to under-18s, both federal, certainly contributed to these results. Unlike the world profile, which points to spirits as the type of alcoholic beverage most consumed, in Brazil, beer accounts for 61.8% of the consumption, followed by spirits (34.3%) and wine (3.4%).

Achieving these results and further goals of a complex and significant problem as the harmful alcohol consumption requires the articulation and engagement of all actors in society.

The need of enrollment of all society actors to the success of the GSA, including the private sector/economic operators.

We share the same understanding of the working document that harmful alcohol use is a complex theme, with multi factorial causes and this characteristic makes tackling the situation much more difficult. However, in some passages, the working document brings statements that oppose the need of the enrollment of all actors for the success of the Global Strategy (GSA).

Aligned with the Global Strategy, economic operators must be enrolled into the development of Public Policies and actively advocate and create strategies to support the harmful alcohol use reduction. As stated at the chapter “National Policies and Measures from GSA, pg 10:

”13.Sustained political commitment, effective coordination, sustainable funding and appropriate engagement of subnational governments as well as from civil society and economic operators are essential for success”(...). (our highlight)

Economic operators can make a positive contribution to reducing the harmful use of alcohol, including through the effective use of their unique expertise, insights, and resources, and through support for co-regulatory systems.

By questioning economic operator’s commitment to public health, the present working document does not appear to be completely aligned with the the UNPD, which clearly stated that economic operators have a role to play in producing positive health outcomes through a whole-of-society approach.

In the last decade, Brazilian industry has led dozens of programs, projects and campaigns, pro-actively, collaborating with government, academia and with the civil society.

We highlight over 1 million people trained in alcohol sales and marketing rules and laws, as well as good drinking practices through point-of-sale networks, employees and major events. In addition, with smart drinking content and referrals in print, tv and social media videos. The private sector in Brazil operates with strict sponsorship and advertisement guidelines on all events, which includes training of staff, responsible consumption activations and water and food offering.

The trade associations Members of the Brazilian Beer Chamber have spent relevant proportion of their marketing budget on social norms advertising campaigns against harmful alcohol use. In this line, the private sector has taken a further step, with pilot interventions taking into consideration real behavior change interventions. We are looking for a multiprofessional approach to fight against the harmful consumption, collaborating with NGO, health care professional and specialized consultancies.

We have recently strengthened the portfolio of low alcohol or zero alcohol products to reinforce the availability of balanced options to consumers. Low- and No- innovations are consistent with the call in the Global Strategy for producers to “consider effective ways to prevent and reduce harmful use of alcohol within their core roles.” Policies that accelerate consumer adoption remain key to expanding their availability.

In addition, we have informative and educational labels, with alcohol gradation and standard warning message.

We consider the continued and perennial actions to reduce harmful alcohol consumption by Brazilian society as strategic, adapting and improving market conditions. In addition, it is important to take into consideration Brazil's social, economic, regulatory and cultural peculiarities in order to implement evidence based Public Policies, which are led by scientific consensus.

The Brazilian Beer chamber presents bellow winning initiatives already implemented and priority areas for future actions:

- Road Safety:

The dry law implemented in Brazil 10 years ago has avoided, since its implementation, 41 thousand deaths and has contributed to the 21,4% reduction of traffic roads crashes at the country's capitals.

[<https://www.gov.br/pt-br/noticias/transito-e-transportes/2020/09/brasil-registra-queda-em-numero-de-mortes-no-transito>]

In addition to campaigns, the industry has been working for over 5 years with road safety programs in partnership with public traffic agencies, developing routines, technologies and integration of actors to reduce fatal accidents. We mention the programs in the state of São Paulo, with a 30% reduction in fatal accidents in 3 years and the other private partnership program, which reduced fatal accidents in the Federal District by 50%. The consolidation of these learnings was formatted in a Road Safety Toolkit and presented by the UN in July 2019 to share best practices.

Brazil has evolved a lot over the past years regarding road safety, and we agree that the strategy of sobriety checkpoints and random breath testing at national level is an essential strategy to improve the road safety and alcohol related road incidents and deaths.

- Partnership between all sectors (government, private sector, academia and civil society) towards higher health care system access:

This initiative has been effective, efficient and transformative in Brazil. Through a Private Public Cooperation program, with management support for industry training, materials and technology; and using the family health system with primary care, we implemented the first program to prevent the harmful use of alcohol through the SBI tool. The project foresees application of 40 thousand interventions, positively impacting the central region of the country - in the Federal District. We consider it a priority to expand this initiative in the coming years, in a scientifically based and sustainable manner within public health structures.

Also, in 2019 the private sector started a new approach towards Health care professionals to empower their actions related to alcohol responsible consumption. More than 30 K nutritionists were reached at Scientific Congresses. Nutritionists were selected due to the primary access to the population and the message multiplication potential of these professionals.

Through the Responsible City Project, consistent actions have been implemented since 2013, in partnership with municipal administrations and the São Paulo State Department of Education, to inhibit the consumption of alcohol by minors. Almost 5 thousand people have been trained directly among

teachers and educational managers, community agents and health professionals, sport and culture educators, fiscal and security agents, social workers, civil society leaders, as well as teenagers and young adults, to strengthen preventive actions and access to primary care.

Planned by an intersectoral and autonomous committee, with the support of the industry, several actions were carried out such as cultural and sports events, directed communication materials, school and training activities, besides the work of health agents and other professionals, who reached more than 2 million teenagers, young adults, adults, parents and professionals. Thus, crucial results were consolidated like the decrease in the alcohol consumption and in the negative consequences of drinking, decrease in the access to purchase, increase in awareness, among other factors of extreme importance for the reduction of harmful use of alcohol and promotion of integral health.

Brazilian Beer chamber understands that much more should be done through a strong partnership with the local Health Care System, academia and civil society to facilitate access to screening, interventions and treatment.

Unfair and unproven conflict of interest on the support of GSA by economic operators

The sector has the interested of promoting a healthier and better relationship with alcohol consumption. The working document makes unfair and unproven statements about this “supposed” conflict of interest and does not show any alternative to tackle it.

The Brewing Sector is highly local, and the success of the business depends on the socio-economic health of the communities where brewers operate. Brewers also have important insights that are important to the decision-making of government and supports the “whole of society” approach championed by the WHO and its leadership.

There is no inherent conflict of interest between the brewers’ interests and those of public health, and no justification to exclude brewers from public policy discussions.

We reinforce thus, that the working document should be reviewed regarding all actions areas to promote better alignment with the UNPD and the Global Strategy, reviewing the suggestions that the private sector should refrain from taking part at public policy development and implementation, harmful consumption reduction campaigns and any other activity that could support the country to reach its health goals.

Focus on reducing harmful use of alcohol

The use of the correct terminology is essential for such document. Scientific evidence and the Global Strategy itself makes a clear distinction between the harmful alcohol consumption - consumption pattern that indeed causes negative collateral effects, not only to the person’s health, but to the whole society - and the consumption of alcohol per se or as a light or moderate level of consumption.

Alcohol consumption per se has low or no health impact and is part of many cultures around the world since the beginning of societies.

Harmful consumption terminology embraces the excessive consumption and goes even further, as the consumption by minors, pregnant women, drink and driving, etc. In other words, it means the kind of consumption that will bring negative effects.

On the other hand, there is a possible alcohol consumption within a balanced lifestyle, and scientific evidence does not indicate that the WHO's effort should focus on this kind of consumption.

Provide the full menu of policy options included in the Global Strategy, other than exclusively SAFER.

The SAFER initiative may be an important tool for some countries, however, the GSA brings a broader effective Policies set, aligned with WHO's orientation, that represents strategies more adaptable to at some WHO Member States, such as Brazil.

Moreover, the working document's first global target proposes tracking progress solely on a country's implementation of the SAFER initiative and fails to recognize progress in implementing any other policies identified at the Global Strategy as a valid metric. The prioritization of the SAFER initiative, despite researchers having identified a lack of evidence in low and middle-income countries regarding the effectiveness of some of the policies included in the initiative, discourages any Policy at all of being implemented.

Science based strategies Public Policies

Any Public Policy regarding the reduction of alcohol consumption, or the GSAP per se must be based exclusively in science -based evidences.

For example, peer-reviewed studies have shown that the effects of increased taxation can vary across different types of drinkers. Some scientific studies show the heaviest drinkers, including heavy episodic drinkers, are the least sensitive to pricing policies. Disproportionate taxation may penalize moderate drinkers and those with limited disposable income.

It is important that only evaluated and cost-effective strategies are proposed on the working GSAP document, such as the prioritization of prevention strategies (references bellow Chapter "Focus on prevention is more cost-effective than treatment").

Focus on prevention is more cost-effective than treatment

We believe that the priority of strategic actions must be the prevention of harmful use of alcohol. That is why we emphasize the immense opportunity for innovation in primary mental health care with a focus on prevention through the use of screening tools and brief intervention (SBIs).

Studies show us that preventing harmful alcohol use is 10 times more economic-effective than treating alcohol abuse. [Source – Available at: <https://iogt.org/wp-content/uploads/2015/03/CostBenefit-of-AlcPrevention.pdf>]. The SBI protocol can have an impact on the behavior of 8 to 12% of the population covered by the tool, according to a study by British professor Peter Anderson, an international reference on the subject [Source – Available at: <https://academic.oup.com/eurpub/article/27/2/345/2622407>]

As mentioned on page 14 of the GSAP working document, countries should facilitate access to screening, brief interventions and treatment. This modeling can be applied in the primary health care network, strengthening networking in the mental health area and being a transforming tool in the risk factor of harmful alcohol consumption. [Source – Available at: <https://www.who.int/publications/i/item/audit-the-alcohol-use-disorders-identification-test-guidelines-for-use-in-primary-health-care>]

The screening and brief intervention in digital / online format, and also through telemedicine (telephone service), has shown very effective results in recent studies and implementations, both formats that allow scale and scope for impact.

This prioritization suggestion is in line with the Plan's strategy proposal, specifically in the areas of health promotion, comprehensive care and attention to diseases and health problems - with due reference to AUDIT and tele-consultation.

Fight against illegal and unrecorded alcohol consumption

In Brazil, the estimated proportion of illegal alcohol is 15.5% (1.2L of per capita consumption of pure alcohol). Recent study conducted by Euromonitor International demonstrate that in many countries, particularly emerging markets, the percentage of unrecorded alcohol can sometimes be more than half of the total alcohol market.

Latin America is not an exception, as one out of every 4 bottles is illicit. The illicit alcohol market creates a serious safety risks for consumers, erodes the rule of law, denies the government much needed fiscal income and makes growth for legal businesses much harder. In Brazil, almost 20% from the total alcohol per capita consumption is unrecorded.

In Brazil, latest WHO report shows that even though there was an expressive per capita alcohol consumption, the percentage of unrecorded alcohol contribution to the consumption has remained similar over the years.

In addition, it is necessary to be cautious with the collateral effect of any possible restriction imposed to the legal alcoholic beverages market. The recent study from Euromonitor International (2020) has shown that the lockdown restriction imposed in Brazil during the pandemic, has led to an 10% increase on illegal alcohol, being the second highest increase in Latin American countries.

Differentiation

The Working Paper refrains from acting on the abundant evidence that alcohol policies in the areas of taxation, availability, and marketing can be adjusted to nudge consumers toward lower-alcohol-strength beverages, significantly reducing alcohol-related harms.

Evidences point that the effects of alcohol consumption depend on what and how one drinks. Rapid consumption of highly concentrated alcohol, for example, carries a higher risk for certain harms.

Using policy levers to nudge consumers toward low-alcohol-strength products can significantly reduce alcohol-related harm and also create incentives for producers to develop low-alcohol-strength products.

Overall, we conclude that if beer production chain is part of the problem, it will consequently be part of the solution. Thus, a thorough debate on the topic involving all interested parties is the path to implement policies to combat the harmful use of alcohol which consequently improves the relationship and perception of alcohol with society and promotes safe consumption of alcoholic beverages.

Contribution to the World Health Organization's web-based consultation on the 6th December of 2020 to the Discussion Paper: "Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol"



The Brazilian National Beer Chamber represents the whole supply chain enrolled with beer production: agriculture raw material suppliers, packaging suppliers, beer industry major producers, small and medium beer producers, the government representatives and technical advisers, and is established within the Brazilian Ministry of Agriculture, Livestock and Supply structure.

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In this sense, the structure of the Global Strategy and the relevant improvements stated on the 2018 UN Political Declaration (UNPD) on non-communicable diseases, must be followed. What includes the enrollment of the economic operator, as well as all society levels, and the Global Strategy (2010) policies set.

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It is essential to highlight that Brazil has shown positive results towards the goal of a 10% reduction of harmful alcohol consumption by 2025. Data from the WHO Global Alcohol and Health Report 2018 indicate that 40% of the population consumed alcohol. There was an **11% reduction in per capita alcohol consumption in the country - from 8.8 liters (L) in 2010 to 7, 8 L, in 2016**. In addition, during this same period, there was a reduction in the rate of alcohol use disorders (from 5.6% to 4.2%, well below the average in the Americas region - 8.2%).

The implementation of the Dry Law (Law No. 11,705 / 2008), and Law No. 13,106 / 2015, which made it a crime to offer alcohol to under-18s, both federal, certainly contributed to these results. Unlike the world profile, which points to spirits as the type of alcoholic beverage most consumed, in Brazil, beer accounts for 61.8% of the consumption, followed by spirits (34.3%) and wine (3.4%).

Achieving these results and further goals of a complex and significant problem as the harmful alcohol consumption requires the articulation and engagement of all actors in society.

The need of enrollment of all society actors to the success of the GSA, including the private sector/economic operators.

We share the same understanding of the working document that harmful alcohol use is a complex theme, with multi factorial causes and this characteristic makes tackling the situation much more difficult. However, in some passages, the working document brings statements that oppose the need of the enrollment of all actors for the success of the Global Strategy (GSA).

Aligned with the Global Strategy, economic operators must be enrolled into the development of Public Policies and actively advocate and create strategies to support the harmful alcohol use reduction. As stated at the chapter “National Policies and Measures from GSA, pg 10:

*“13.Sustained political commitment, effective coordination, sustainable funding and **appropriate engagement** of subnational governments as well as from civil society and **economic operators are essential for success**”(…). (our highlight)*

Economic operators can make a positive contribution to reducing the harmful use of alcohol, including through the effective use of their unique expertise, insights, and resources, and through support for co-regulatory systems.

By questioning economic operator’s commitment to public health, the present working document does not appear to be completely aligned with the the UNPD, which clearly stated that economic operators have a role to play in producing positive health outcomes through a whole-of-society approach.

In the last decade, Brazilian industry has led dozens of programs, projects and campaigns, pro-actively, collaborating with government, academia and with the civil society.

We highlight over 1 million people trained in alcohol sales and marketing rules and laws, as well as good drinking practices through point-of-sale networks, employees and major events. In addition, with smart drinking content and referrals in print, tv and social media videos. The private sector in Brazil operates with strict sponsorship and advertisement guidelines on all events, which includes training of staff, responsible consumption activations and water and food offering.

The trade associations Members of the Brazilian Beer Chamber have spent relevant proportion of their marketing budget on social norms advertising campaigns against harmful alcohol use. In this line, the private sector has taken a further step, with pilot interventions taking into consideration real behavior change interventions. We are looking for a multiprofessional approach to fight against the harmful consumption, collaborating with NGO, health care professional and specialized consultancies.

We have recently strengthened the portfolio of low alcohol or zero alcohol products to reinforce the availability of balanced options to consumers. Low- and No- innovations are consistent with the call in the Global Strategy for producers to “consider effective ways to prevent and reduce harmful use of alcohol within their core roles.” Policies that accelerate consumer adoption remain key to expanding their availability.

In addition, we have informative and educational labels, with alcohol gradation and standard warning message.

We consider the continued and perennial actions to reduce harmful alcohol consumption by Brazilian society as strategic, adapting and improving market conditions. In addition, it is important to take into consideration Brazil's social, economic, regulatory and cultural peculiarities in order to implement evidence based Public Policies, which are led by scientific consensus.

The Brazilian Beer chamber presents bellow winning initiatives already implemented and priority areas for future actions:

- **Road Safety:**

The dry law implemented in Brazil 10 years ago has avoided, since its implementation, 41 thousand deaths and has contributed to the 21,4% reduction of traffic roads crashes at the country's capitals.

[<https://www.gov.br/pt-br/noticias/transito-e-transportes/2020/09/brasil-registra-queda-em-numero-de-mortes-no-transito>]

In addition to campaigns, the industry has been working for over 5 years with road safety programs in partnership with public traffic agencies, developing routines, technologies and integration of actors to reduce fatal accidents. We mention the programs in the state of São Paulo, with a 30% reduction in fatal accidents in 3 years and the other private partnership program, which reduced fatal accidents in the Federal District by 50%. The consolidation of these learnings was formatted in a Road Safety Toolkit and presented by the UN in July 2019 to share best practices.

Brazil has evolved a lot over the past years regarding road safety, and we agree that the strategy of sobriety checkpoints and random breath testing at national level is an essential strategy to improve the road safety and alcohol related road incidents and deaths.

- **Partnership between all sectors (government, private sector, academia and civil society) towards higher health care system access:**

This initiative has been effective, efficient and transformative in Brazil. Through a Private Public Cooperation program, with management support for industry training, materials and technology; and using the family health system with primary care, we implemented the first program to prevent the harmful use of alcohol through the SBI tool. The project foresees application of 40 thousand interventions, positively impacting the central region of the country - in the Federal District. We consider it a priority to expand this initiative in the coming years, in a scientifically based and sustainable manner within public health structures.

Also, in 2019 the private sector started a new approach towards Health care professionals to empower their actions related to alcohol responsible consumption. More than 30 K nutritionists were reached at Scientific Congresses. Nutritionists were selected due to the primary access to the population and the message multiplication potential of these professionals.

Through the Responsible City Project, consistent actions have been implemented since 2013, in partnership with municipal administrations and the São Paulo State Department of Education, to inhibit the consumption of alcohol by minors. Almost 5 thousand people have been trained directly among teachers and educational managers, community agents and health professionals, sport and culture educators, fiscal and security agents, social workers, civil society leaders, as well as teenagers and young adults, to strengthen preventive actions and access to primary care.

Planned by an intersectoral and autonomous committee, with the support of the industry, several actions were carried out such as cultural and sports events, directed communication materials, school and training activities, besides the work of health agents and other professionals, who reached more than 2 million teenagers, young adults, adults, parents and professionals. Thus, crucial results were consolidated like the decrease in the alcohol consumption and in the negative consequences of

drinking, decrease in the access to purchase, increase in awareness, among other factors of extreme importance for the reduction of harmful use of alcohol and promotion of integral health.

Brazilian Beer chamber understands that much more should be done through a strong partnership with the local Health Care System, academia and civil society to facilitate access to screening, interventions and treatment.

Unfair and unproven conflict of interest on the support of GSA by economic operators

The sector has the interested of promoting a healthier and better relationship with alcohol consumption. The working document makes unfair and unproven statements about this “supposed” conflict of interest and does not show any alternative to tackle it.

The Brewing Sector is highly local, and the success of the business depends on the socio-economic health of the communities where brewers operate. Brewers also have important insights that are important to the decision-making of government and supports the “whole of society” approach championed by the WHO and its leadership.

There is no inherent conflict of interest between the brewers’ interests and those of public health, and no justification to exclude brewers from public policy discussions.

We reinforce thus, that the working document should be reviewed regarding all actions areas to promote better alignment with the UNPD and the Global Strategy, reviewing the suggestions that the private sector should refrain from taking part at public policy development and implementation, harmful consumption reduction campaigns and any other activity that could support the country to reach its health goals.

Focus on reducing *harmful use* of alcohol

The use of the correct terminology is essential for such document. Scientific evidence and the Global Strategy itself makes a clear distinction between the harmful alcohol consumption - consumption pattern that indeed causes negative collateral effects, not only to the person’s health, but to the whole society - and the consumption of alcohol *per se* or as a light or moderate level of consumption.

Alcohol consumption *per se* has low or no health impact and is part of many cultures around the world since the beginning of societies.

Harmful consumption terminology embraces the excessive consumption and goes even further, as the consumption by minors, pregnant women, drink and driving, etc. In other words, it means the kind of consumption that will bring negative effects.

On the other hand, there is a possible alcohol consumption within a balanced lifestyle, and scientific evidence does not indicate that the WHO’s effort should focus on this kind of consumption.

Provide the full menu of policy options included in the Global Strategy, other than exclusively SAFER.

The SAFER initiative may be an important tool for some countries, however, the GSA brings a broader effective Policies set, aligned with WHO’s orientation, that represents strategies more adaptable to at some WHO Member States, such as Brazil.

Moreover, the working document’s first global target proposes tracking progress solely on a country’s implementation of the SAFER initiative and fails to recognize progress in implementing any other

policies identified at the Global Strategy as a valid metric. The prioritization of the SAFER initiative, despite researchers having identified a lack of evidence in low and middle-income countries regarding the effectiveness of some of the policies included in the initiative, discourages any Policy at all of being implemented.

Science based strategies Public Policies

Any Public Policy regarding the reduction of alcohol consumption, or the GSAP *per se* must be based exclusively in science -based evidences.

For example, peer-reviewed studies have shown that the effects of increased taxation can vary across different types of drinkers. Some scientific studies show the heaviest drinkers, including heavy episodic drinkers, are the least sensitive to pricing policies. Disproportionate taxation may penalize moderate drinkers and those with limited disposable income.

It is important that only evaluated and cost-effective strategies are proposed on the working GSAP document, such as the prioritization of prevention strategies (references bellow Chapter “Focus on prevention is more cost-effective than treatment”).

Focus on prevention is more cost-effective than treatment

We believe that the priority of strategic actions must be the prevention of harmful use of alcohol. That is why we emphasize the immense opportunity for innovation in primary mental health care with a focus on prevention through the use of screening tools and brief intervention (SBIs).

Studies show us that preventing harmful alcohol use is 10 times more economic-effective than treating alcohol abuse. [Source – Available at: <https://iogt.org/wp-content/uploads/2015/03/CostBenefit-of-AlcPrevention.pdf>]. The SBI protocol can have an impact on the behavior of 8 to 12% of the population covered by the tool, according to a study by British professor Peter Anderson, an international reference on the subject [Source – Available at: <https://academic.oup.com/eurpub/article/27/2/345/2622407>]

As mentioned on page 14 of the GSAP working document, countries should facilitate access to screening, brief interventions and treatment. This modeling can be applied in the primary health care network, strengthening networking in the mental health area and being a transforming tool in the risk factor of harmful alcohol consumption. [Source – Available at: <https://www.who.int/publications/i/item/audit-the-alcohol-use-disorders-identification-test-guidelines-for-use-in-primary-health-care>]

The screening and brief intervention in digital / online format, and also through telemedicine (telephone service), has shown very effective results in recent studies and implementations, both formats that allow scale and scope for impact.

This prioritization suggestion is in line with the Plan's strategy proposal, specifically in the areas of health promotion, comprehensive care and attention to diseases and health problems - with due reference to AUDIT and tele-consultation.

Fight against illegal and unrecorded alcohol consumption

In Brazil, the estimated proportion of illegal alcohol is 15.5% (1.2L of per capita consumption of pure alcohol). Recent study conducted by Euromonitor International demonstrate that in many countries, particularly emerging markets, the percentage of unrecorded alcohol can sometimes be more than half of the total alcohol market.

Latin America is not an exception, as one out of every 4 bottles is illicit. The illicit alcohol market creates a serious safety risks for consumers, erodes the rule of law, denies the government much needed fiscal income and makes growth for legal businesses much harder. In Brazil, almost 20% from the total alcohol *per capita* consumption is unrecorded.

In Brazil, latest WHO report shows that even though there was an expressive *per capita* alcohol consumption, the percentage of unrecorded alcohol contribution to the consumption has remained similar over the years.

In addition, it is necessary to be cautious with the collateral effect of any possible restriction imposed to the legal alcoholic beverages market. The recent study from Euromonitor International (2020) has shown that the lockdown restriction imposed in Brazil during the pandemic, has led to an 10% increase on illegal alcohol, being the second highest increase in Latin American countries.

Differentiation

The Working Paper refrains from acting on the abundant evidence that alcohol policies in the areas of taxation, availability, and marketing can be adjusted to nudge consumers toward lower-alcohol-strength beverages, significantly reducing alcohol-related harms.

Evidences point that the effects of alcohol consumption depend on what and how one drinks. Rapid consumption of highly concentrated alcohol, for example, carries a higher risk for certain harms. Using policy levers to nudge consumers toward low-alcohol-strength products can significantly reduce alcohol-related harm and also create incentives for producers to develop low-alcohol-strength products.

Overall, we conclude that if beer production chain is part of the problem, it will consequently be part of the solution. Thus, a thorough debate on the topic involving all interested parties is the path to implement policies to combat the harmful use of alcohol which consequently improves the relationship and perception of alcohol with society and promotes safe consumption of alcoholic beverages.

Brewers Association of Australia

Country/Location: Australia

URL: www.brewers.org.au

Submission

Yes the working document on behalf of the Brewers Association of Australia.

I will upload our comments in the accompanying letter.

Attachment(s): 1

00295_61_20201211-brewersau-who-consultation-draft-action-plan.pdf



December 11, 2020

Alcohol, Drugs and Addictive Behaviours Unit
World Health Organisation Secretariat
Geneva Switzerland

Submitted via secure web portal

Submission to the select consultation on the Draft Action Plan to Implement the Global Strategy to reduce the harmful use of alcohol.

Thank you for the opportunity to submit on behalf of the major brewers of Australia. We welcome the chance to consult on this important draft document to further the work in reducing the harmful consumption of alcohol.

In summary, we argue that the Australian context presents a number of examples as to why certain elements of the current Working Document for Draft Action Plan could be improved and why there is opportunity to include a range of policy options as part of a whole-of-society response to the harmful use of alcohol.

The Brewers' Association of Australia is a member of the World Brewing Alliance and supports and endorses their submission in complement of this submission.

About the Brewers' Association of Australia

The Brewers' Association of Australia represents Australia's oldest breweries, with histories spanning more than 150 years and with custody of many of the country's most iconic brands. Domestically brewed beer underpins approximately \$AUD16 billion of economic activity per annum and the employment of 100,000 people (direct and indirect). The Brewers' Association members account for 85% of the Australian beer volume and collectively make a substantial contribution to Australian manufacturing and Australian agriculture, with the impact spanning to transport and logistics, hospitality and retail in almost every town and city in the country.ⁱ

Opportunities to improve the Draft Action Plan

1. We strongly encourage that there be a full menu of policy options for identified priorities, to ensure national and local contexts can be properly considered by member states. This 'menu' approach is a crucial element of Australia's National Alcohol Strategy 2018 – 2028.ⁱⁱ
2. There is clear evidence that creating a broader range of lower alcohol products (and the growing "no" alcohol segment) produces long term tangible benefits. This strategy should be clearly called out as an option in the Action Plan. Australia leads the world in the development of 3.5% Alcohol by Volume (ABV) beer, with the two highest selling beers in the market containing this ABV. Mid, low and no-alcohol beers now account for more than 25% of beer sales in Australia, with the category continuing to grow year-on-year.ⁱⁱⁱ
3. Economic operators should be included in dialogue about policy solutions that can reduce the harmful use of alcohol as part of a whole-of-society approach, and the Australian context has a number of examples where industry-led initiatives have shown considerable benefit.

Information and examples to support these opportunities is detailed below, including important context regarding consumption patterns and the impact of COVID-19.

Continued, positive trajectory of Australian data regarding harmful use of alcohol

While the Draft Action Plan does not contain much confidence in success or progress since the Global Alcohol Strategy was endorsed, pleasingly the Australian data across a range of sources shows clear, positive change and a tangible reduction in harmful use of alcohol.

Encouragingly, the long-term moderation trend continues. As individuals, and as a society, Australians today are better equipped and more informed about responsible alcohol consumption than ever before. Reductions in per capita consumption and rates of harmful consumption are clear in a number of taxation and health data collated by Government.

According to the Australian Bureau of Statistics, Australians today are drinking less alcohol overall in more than 55 years. Across all alcoholic beverages, there were 9.51 litres of pure alcohol available for consumption in 2017-18 for every person in Australia aged 15 years and over, with the trending showing a decline of around 1.1% per year over the last decade^{iv}

Other general trend data points include:

- 78.8% of Australians aged 18 years or more consumed alcohol in the last 12 months, comprising 84.5% of men and 73.3% of women.^v
- Around 40% of Australians consume alcohol weekly. Just 6% drink daily – down from 9% in 2007.^{vi}
- 84% of Australians drink within recommended Government guidelines. Fewer people in Australia drink alcohol in quantities that exceed the lifetime risk – down to 16.1% in 2017-18 compared to 21% in 2004.^{vii}

In terms of minors and young adults, the data is also showing long term positive change:

	2004	2007	2010	2013	2016
Abstinence rates among 12-17 year olds	54.3%	56.5%	63.6%	72.3%	82%
Average age of first drink	14.7	14.9	15.2	15.7	16.1
Proportion of 12-17 year olds drinking at lifetime risky patterns	6.4%	5.4%	4.2%	2.6%	1.3%
Proportion of 12-17 year olds at risk of drinking harm on a single occasion	17.2%	16.6%	14.1%	8.7%	5.4%

Table: Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2016, September 2017.

Impacts of COVID-19 on the Australian brewing sector

This year has been very challenging for the Australian beer industry, with the complete closure hospitality sector for months along with beer being the least-favoured at-home beverage combining to create considerable loss of volume and revenue. Accelerated market decline in the June quarter with keg sales down more than 85% and retail beer sales were also down 3%.^{viii} The abrupt closure of bars, pubs and restaurants saw more than 20 million schooners (425ml/15 fluid ounce vessels) of draught beer poured down the drain due to beer spoilage.

The total closure of the hospitality sector resulted in at least 440,000 Australians losing their jobs, affecting every community in the country. While we are fortunate in Australia to have managed the health response to a point where hospitality operators can now re open, restrictions remain in place and normal trade will not resume for some time. It's important to highlight that despite short-lived periods of retail purchasing at the beginning of the Covid-19 lockdowns (which garnered considerable media reporting), overall beer consumption fell in Australia as the volume from on-premise sales was not compensated for in off premise sales.

This fact has been supported in a recent study by academics at Monash University in Victoria Australia, where authors studied beer excise tax receipts. There was no evidence of off-trade sales increases while clear decreases in on-trade sales^{ix}. Usefully, Australia has differential





beer excise rates for keg/barrelled beer vs packaged beer allowing this data to be easily collected and analysed.

Australia's National Alcohol Strategy focuses on a full range of policy options for jurisdictions to consider, recognising different tiers of Government and the need to contextualise the response.

The Commonwealth of Australia released the [National Alcohol Strategy 2019-2028](#) to guide State and Federal Governments policy in relation to reducing the harmful use of alcohol.

A core tenet of this new strategy is a full list of policy responses and options for each identified objective. The list of options also gives guidance to which jurisdictions are the most relevant to consider and enact them.

We note the Working Document draft sees a departure from the full menu of policy options as detailed in the Global Alcohol Strategy 2010, and instead largely focuses on the narrower list of priorities summarised by the SAFER initiative.

We commend the approach of the Australian Commonwealth Government in producing their National Alcohol Strategy with a full menu of policy options.

Australian success in the adoption of lower strength beers

The Working Document should highlight and encourage innovation and promotion of low and no alcohol products, restating the policy recommendation from the Global Alcohol Strategy 2010 (*Area 8, D. Reduce the alcoholic strength inside different beverage categories*).

This is a clear example of economic operators work to further the whole-of-society approach to reducing the harmful use of alcohol via their commercial operations.

The concept of encouraging or nudging consumers towards lower-alcohol products is a widely accepted and successful approach and there is an increasing evidence base that this is an effective and cost-effective way to tackle harmful consumption.^x

Australia has seen steady growth of 3.5% Alcohol by Volume (ABV) beers since the early 1990s. The Australian market leads the world in both innovation and consumer adoption of lower strength beers.

Since 2010, there has been further acceleration in growth in the 3.5% ABV beer category. Due to this innovation and investment in the segment, the two highest selling beers in Australia currently are 3.5% ABV beers. Mid-strength (3.5% ABV) and low-strength beers now account for more than one-quarter of all local beer sales at 26.5% of total sales volume. Mid-strength makes up 22.5% of all beer sales in Australia. All three of Australia's major brewers (CUB, Lion and Coopers) also produce non-alcohol beers^{xi}. The Australian Government has designed its beer excise regime to incentivise this innovation, giving preferential taxation levels to lower strength beers.

Industry can play a role in raising standards, as an important demonstration of the whole-of-society approach to reducing the harmful use of alcohol.

There is a clear opportunity for producers, distributors and retailers to contribute to the whole-of-society approach to reduce the harmful use of alcohol. The Draft Action Plan could be improved by highlighting the opportunities in this space, where appropriate to national and local contexts.

There are numerous examples in Australia of industry-led or co-regulated schemes that have been instrumental at raising standards in terms of responsible sales and marketing of alcoholic beverages.

The most recent example of this is the Retail Drinks Australia Code for the Online Sales of Alcohol^{xii}, which was launched in July 2019 and covers more than 80% of all alcohol sold and delivered via e-commerce. This was an industry-led initiative to develop new standards to protect minors and extend responsible service of alcohol standards in the emerging direct-to-home alcohol delivery sector.

This world-leading code is now inspiration for a range of other in-market codes.

Conclusion

Once again thank you for the opportunity to submit on behalf of the Australian brewing industry to this important consultation.

We would welcome the opportunity to engage and provide perspectives on future stages of this process.

Signed of behalf of Brewers Association of Australia



Dan Holland

Regulatory Committee Member, Brewers Association of Australia
External Relations Director, Lion Group

ⁱ <https://www.acilallen.com.au/projects/economic-modelling-and-analysis/economic-contribution-of-the-australian-brewing-industry-2017-2018>

ⁱⁱ <https://www.health.gov.au/resources/publications/national-alcohol-strategy-2019-2028>

ⁱⁱⁱ <https://www.acilallen.com.au/projects/economic-modelling-and-analysis/economic-contribution-of-the-australian-brewing-industry-2017-2018>

^{iv} <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/apparent-consumption-alcohol-australia/latest-release>

^v [Australian Bureau of Statistics, National Health Survey: First Results 2017-18, December 2018](#)

^{vi} [Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2016, September 2017](#)

^{vii} [Australian Bureau of Statistics, National Health Survey: First Results 2017-18, December 2018.](#)

^{viii} [1 Impact of COVID-19 on the Drinks Industry ABA – Industry report on coronavirus](#)

^{ix} [Vandenberg, Brian, Michael Livingston, and Kerry O'Brien. "When the pubs closed: Beer consumption before and after the first and second waves of COVID-19 in Australia." *Addiction* \(2020\).](#)

^x [Griffith, Rachel, Martin O'Connell, and Kate Smith. "Tax design in the alcohol market." *Journal of public economics* 172 \(2019\): 20-35 ; WHO Regional Office for Europe, "Alcohol policy impact case study: the effects of alcohol control measures on mortality and life expectancy in the Russian Federation \(2019\)."](#)

^{xi} <https://www.acilallen.com.au/projects/economic-modelling-and-analysis/economic-contribution-of-the-australian-brewing-industry-2017-2018>

^{xii} <http://www.code.retaildrinks.org.au/>

Brewers of Romania Association

Country/Location: Romania

URL: www.berariromaniei.ro

Submission

Brewers of Romania represent the common voice of the local beer industry, bringing together leading beer producers in Romania, representing more than 80% of the market. Our objectives are to support the development of a sustainable brewing sector, promote a transparent competitive environment, ensure equal and fair tax treatment for the industry, foster cross-sectorial cooperation to support the drinking culture and responsible alcohol use.

Local market trends demonstrate how increased consumption of low alcohol beverages, in sectors such as brewing where there is also a growth in lower and non-alcohol versions, can actually result in improved health outcomes, as consumers switch from higher alcohol products.

Authorities treat different alcoholic beverages differently through fiscal legislation or marketing freedoms.

The Working Document fails to reflect this reality and to emphasize the role of alcohol policies in the areas of taxation, availability and marketing to encourage consumer preferences for lower-alcohol-strength beverages, significantly reducing alcohol-related harms.

Collaboration is critical for creating “win-win” situations like the beer sector’s leadership on labelling and the spread of low- and no-alcohol products.

Attachment(s): 1

00353_23_201211-who-consultation-romania-vf.pdf



With regards to the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol, we would like to submit hereby our comments and suggestions for consideration:

About the Brewers of Romania

Brewers of Romania represent the common voice of the local beer industry, bringing together leading beer producers in Romania, representing more than 80% of the market. Our objectives are to support the development of a sustainable brewing sector, promote a transparent competitive environment, ensure equal and fair tax treatment for the industry, foster cross-sectorial cooperation to support the drinking culture and responsible alcohol use. In 2008, the Brewers of Romania joined the larger family of European brewers, represented by the Brewers of Europe.

Consumption trends in Romania

The Romanian beer market was stable over the last 5 years (1-2% increase per year), but maturing in terms of beer preferences. In addition to that, brewers have reported a downward trend in the average alcohol content in beer sold in Romania, while N/A and low-alcohol beer witnessed significant volume hikes. In the last 5 years before Covid19 crisis, the non-alcoholic and beer mixes segments increased constantly, with 42% for N/A, respectively 34% for mixes (2019 compared with 2015), as consumers switch from higher alcohol products.

It should be stressed, that adolescents follow drinking patterns demonstrated by adults. Results of ESPAD¹ survey conducted on minors since 1995 reveal a continuous downward trend in beer. The most recent 2019 ESPAD report shows significant declines for Romania in both underage drinking and adolescent binge drinking:

- Growing abstinence among teenagers, both among boys and girls; the level of abstinence among young Romanians increased above the European average.
- Decrease in alcohol consumption: (-)3,7 l for segment 15 - 19 yo, (-)4,8 l, for segment 20 - 24 yo
- Decrease in episodes of alcohol abuse in the two age groups analyzed, both among boys and girls, at the level at which they were approaching the European average.
- Romania is among the countries with one of the lowest rate in Europe, when it comes to how easy alcohol may be obtained, compared with other substances. However, as expected, alcohol remains easier to access.

These data demonstrate how increased consumption of low alcohol beverages, in sectors such as brewing where there is also a growth in lower and non-alcohol versions, can actually result in improved health outcomes, as consumers switch from higher alcohol products.

Role of lower alcohol beverages

Authorities treat different alcoholic beverages differently through fiscal legislation or marketing freedoms.

The Working Document fails to reflect this reality and to emphasize the role of alcohol policies in the areas of taxation, availability and marketing to encourage consumer preferences for lower-alcohol-strength beverages, significantly reducing alcohol-related harms.

The evidence shows that the effects of alcohol consumption depend on what you drink and how you drink it. Rapid consumption of highly concentrated alcohol, for example, carries a higher risk for certain problems.

Alcohol policy should focus on removing destructive drinking, which is directly responsible for damage to health and the society at large. Using policy pedals to shift consumption toward lower-alcohol-strength products can significantly reduce alcohol-related harm while also creating incentives for producers to create lower-alcohol strength products. Numerous alcohol policy experts have called for more extensive implementation of this approach.

¹ ESPAD Report 2019, Results from the European School Survey Project on Alcohol and Other Drugs



Where business and public health interests meet

The Working Document also claims that there is a conflict between the interests of alcoholic drinks producers and the interests of public health. However, brewers also have significant insights that are important to the adoption of public policies and support the collaborative approach advocated by the WHO.

1. *Commitment on labelling at both EU and local levels*

The Brewers of Europe has for example committed, in the absence of a legal obligation set in EU law, to voluntarily roll out ingredients and calorie labelling across the continent. The brewing sector is voluntarily doing that, as non-alcoholic beverages and foods are legally obliged to do that. The ambition is to ensure that all beer packages carry this information in 2022. Members of the Brewers of Romania have actively contributed to the achievement of this commitment, meeting all interim targets so far.

2. *Social responsibility information campaigns*

The Romanian Brewers Association run every year social responsibility campaigns - [Don't Drink & Drive](#) in partnership with the Romanian Police, aimed at discouraging alcohol consumption when driving and [Alcohol doesn't make you big](#), addressed to high-school students, implemented with the support of the Ministry for Education, aimed at preventing alcohol consumption beyond the legal drinking age and educate on responsible life choices.

Additionally, member companies are also running consistent public campaigns, aimed at promoting moderation in alcohol consumption and informing on associated risks. Examples of such campaigns are: [Zero to thousand](#), an application for drivers to control their blood alcohol level and [#9with0](#), a "9 months with zero alcohol" awareness campaign about the risks of alcohol consumption during pregnancy, [Zero Zone](#), a dedicated area in outlets for low- and no-alcohol drink.

3. *Low and no-alcohol beer*

Romanian brewers have also invested heavily in the development and adoption of low- and non-alcohol versions, by expanding their range of products. Many new such assortments were introduced on the local market over the last 5 years.

These innovations are a response to consumer request for lower alcohol products, offering responsible consumer choice in situations where alcohol consumption is either inadvisable (for example when driving, pregnant etc.) or when a consumer simply wishes to consume beer but also with less or no alcohol.

Collaboration is critical for creating "win-win" situations like the beer sector's leadership on labelling and the spread of low- and no-alcohol products.

Impact of COVID crisis on the brewing sector

Covid crisis have a negative impact on the beer market, by the drop in sales.

In the first 6 months after the start of the Covid-19 crisis (March - August 2020), the local beer industry recorded a decrease of about 7%², in volume due to emergency measures that led to the lockdown of the Horeca sector, which represents 15% of the beer sales in Romania. Even if household consumption has risen slightly during Covid pandemic, it is unlikely to compensate the decline in Horeca.

In response to this crisis, Brewers of Romania initiated #SOSHoreCa, a campaign of solidarity with the hospitality industry, which aims to draw consumers' attention to the economic situation in the hospitality sector, strongly affected by the interruption of activity during the lockdown.

Supporting the recovery of the hospitality sector as a safe and regulated environment will support the nudging of consumers towards lower alcohol beverages.

² Brewers of Romania Association Mid-Year report

British Beer and Pub Association

Country/Location: United Kingdom of Great Britain and Northern Ireland

Submission

The attached submission is made on behalf of the UK beer sector and is made in addition to submissions made on behalf of the wider alcohol beverage sector. The intention of this submission is to highlight the role and opportunities that exist specifically for beer with regards to the implementation of the Global Alcohol Strategy as a lower strength beverage, including the low and no alcohol beer category, and in particular in offering consumers a route to lower strength options from higher strength alternatives.

Attachment(s): 1

00359_28_joint-bbpa-siba-camra-beer-supplement-to-gas-working-document-consultation-11-december-2020.pdf

Web-Based Consultation on Working Document for Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Introduction

This submission is made on behalf of the British Beer and Pub Association (BBPA) and Society of Independent Brewers (SIBA); the trade bodies that represent UK brewers, as well as the Campaign for Real Ale (CAMRA) which is Europe's largest single issue consumer organisation representing over 190,000 beer drinkers across the UK. Between us we represent over 95% of the beer brewed in the UK as well as those who drink and enjoy our national drink.

We welcome the opportunity to comment on the draft working document for development of an action plan to strengthen the implementation of the Global Alcohol Strategy to reduce the harmful use of alcohol. The following points we would raise in connection with the brewing sector in the UK as producers of the lowest strength alcohol beverage category and ask these be taken into consideration in the ongoing process to develop the action plan and which are supplementary to points made by the wider alcoholic drinks sector.

Consumption Trends between 2010 and 2018

A global, declining trend in alcohol consumption is broadly mirrored in declining rates of alcohol consumption in the UK and the wider European Union. So too however are key indicators associated with alcohol harm including rates of heavy episodic drinking, drink driving accidents and fatalities and underage drinking.

It is important to note that since 2010, whilst beer consumption has remained broadly flat, the average strength of beer has fallen from 4.5% ABV - 4.2% ABV and which coincides with the decrease in alcohol harm indicators. This clearly demonstrates the opportunity for lower alcohol beverages, including the huge growth and diversity of both the low and no alcohol beer category, to address alcohol harm by providing a route to consumers from higher strength drinks.

Whereas the UK Department for Health and Social Care Prevention Green Paper (2019) and the Government's ongoing alcohol duty review both acknowledge regulatory levers that might be used successfully to nudge consumers towards lower alcohol strength drinks, this is missed within the Working Document. Such methods are supported by a recent study which states that "*a regulatory tax environment should be introduced to ensure a level-playing field favouring lower alcohol concentration across all beer products.*" (Anderson, P., E. J. Llopis, & J. Rehm. (2020) [Evaluation of Alcohol Industry Action to Reduce the Harmful Use of Alcohol: Case Study from Great Britain.](#)

Existing Achievements and Opportunities for Beer

The WHO Working Document argues that there is an inherent conflict between the interests of alcoholic drinks producers and the interests of public health which is used to justify excluding all drinks sectors from all discussions on public health policy. However, we believe that there is no inherent conflict of interest between the brewers' interests and those of public health, and no justification to de facto exclude brewers from all public policy discussions.

The brewing sector is highly local, and the success of the business depends on the socio-economic health of the communities where brewers operate. UK brewing is a significant contributor to the circular economy and over 80% of the beer that is drunk in the UK is brewed in the UK. Brewers also have important insights that are important to the decision-making of governments and support the "whole of society" approach championed by the WHO and its leadership:

- UK brewers have demonstrated time and again their commitment as responsible businesses through engagement with Government public health initiatives and in support of the promotion of responsible alcohol consumption:
 - *Support for the UK Government Public Health Responsibility Deal (PHRD) via a specific, targeted pledge to removal alcohol units from the market. Voluntary labelling of additional health related information on alcohol beverage labels, including alcohol unit indications, responsibility messaging*
 - *Many of the initiatives developed through the PHRD continue today through the active and ongoing reduction of strength of key brands and increased production of low and no alcohol beers.*
 - *The beer industry has committed to support independent groups such as the Drinkaware Trust and the Portman Group who undertake, through direct provision of information and responsible promotion and marketing, encourage responsible drinking habits among consumers, while fostering a balanced understanding of alcohol-related issues and promoting targeted interventions to support and reduce the minority of drinkers who misuse alcohol.*
- BBPA members have committed to supporting a wider EU initiative, in the absence of a legal obligation set in EU or UK law, to voluntarily roll out ingredients and calorie labelling:
 - *The brewing sector is voluntarily doing so in exactly the same manner in which non-alcoholic beverages and foods are legally obliged to do so.*
 - *The ambition is to ensure that all pre-packed beer containers carry this information by 2022, with interim EU targets being met thus far.*
- Beer represents the lowest strength alcohol beverage category available to consumers in the UK with an average strength of 4% ABV. In addition, domestic production volumes for low alcohol beer have grown considerably by over 300%

between 2013 and 2019, albeit from a small base. This increasing popularity has driven increased diversity and innovation including the establishment of new brewing companies which focus solely on production of low alcohol beers (<0.5% ABV) as well as significant investment in the development of existing brewery infrastructure and capabilities for alcohol removal to enable increased production of alcohol free beer (<0.05% ABV). Policies that support further innovation and accelerate consumer adoption, including alignment of UK definitions with other European and key global markets, remain key to expanding the availability of low and alcohol free beer further:

- *These innovations are responsive to consumer demand for lower alcohol products, offering responsible consumer choice in situations where alcohol consumption is either inadvisable (for example when driving, pregnant etc.) or when a consumer simply wishes to consume beer but also to consume less or no alcohol.*
- *Non- and low- alcohol innovations are consistent with the call in the Global Strategy for producers to “consider effective ways to prevent and reduce harmful use of alcohol within their core roles.”*

Impact of COVID-19

The COVID-19 crisis has devastated the hospitality sector. We would caution against the development of alcohol policies directly on the basis of experiences during the pandemic and which has offered insights into their impact on the consumption of different alcoholic beverages:

- In the UK, contrary to many anecdotal observations, the crisis has not led to increased per capita beer consumption, which has been specifically and particularly impacted by the closures of the hospitality sector.
- Beer is typically consumed in social settings and the full or partial closure of these safe, regulated environments, combined with further restrictions on social interactions in other private settings, has meant that the significant reductions in on-trade beer sales (forecast to be 54% down on 2019) have not been matched at all by any increase in beer sales (forecast to be up 24% on 2019) from the on-trade retail sector.
- The UK beer market is forecast to have declined by 11.2% overall on 2019, meaning a major drop in the consumption of lower alcohol beverages, due entirely to the closure of the hospitality sector.
- Supporting the recovery of the hospitality sector as a safe and regulated environment will support the nudging of consumers towards lower alcohol beverages.
- Pubs play a vital role in bringing people together, providing an environment for safe, inclusive socialisation, which can often provide a lifeline; particularly for those who live alone or in isolation. Longer term closures of pubs restricts access to the communities they serve and compounds the mental health aspects

11th December 2020

associated with ongoing restrictions as well as removing an environment that has been proven to support positive mental health impacts more broadly.

Bundesverband der Deutschen Spirituosen-Industrie und -Importeure e. V. (BSI)

Country/Location: Germany

Submission

The members of the “Bundesverband der Deutschen Spirituosen-Industrie und -Importeure e. V. - BSI (Federal Association of the German Spirits Industry and Importers) have been committed to the responsible use of alcoholic beverages for decades. As much as alcoholic beverages are an integral part of tradition and culture, the dangers of alcohol abuse should not be underestimated. Personal responsibility and risk competence are the central aspects of a responsible approach to alcoholic beverages. The responsible consumption of alcoholic beverages is not the problem, but the abuse of the products. The aim must therefore be to implement a policy oriented towards the causes of alcohol abuse. This requires an open and fact-based dialogue between all socially relevant groups. BSI members have been facing up to their responsibility through various institutions for decades. In particular, preventive measures to educate people will remain important in the future, in addition to the existing laws - because: Education and personal responsibility are mutually dependent.

Attachment(s): 2

00323_06_bsi-response-to-the-who-consultation-12-2020.pdf

00323_07_annex-1-4.pdf

Geschäftsstelle Bonn
URSTADTSTRASSE 2
53129 BONN
POSTFACH 15 02 23
53041 BONN
TELEFON: 0228/53994-0
TELEFAX: 0228/53994-20
E-MAIL: info@bsi-bonn.de
INTERNET: www.spirituosen-verband.de

Büro Brüssel
RUE DU LUXEMBOURG 47-51
1050 BRUXELLES
BELGIEN
TELEFON: 0032/2/2311669
TELEFAX: 0032/2/2309886
E-MAIL: bruessel@bsi-bonn.de

December 2020

BSI Response to the WHO Consultation of the first draft of the working document on the global alcohol strategy to reduce the harmful use of alcohol

Dear Sir or Madam,

We would like to thank the World Health Organisation - in the name of our association, the Bundesverband der Deutschen Spirituosen-Industrie und -Importeure e. V. – BSI (Federal Association of the German Spirits Industry and Importers) - for the opportunity to make a contribution to the WHO's "Global strategy to reduce the harmful use of alcohol".

As members of the BSI in Germany, the spirits manufacturers and importers have been committed to the responsible use of alcoholic beverages for decades. As much as alcoholic beverages are an integral part of tradition and culture, the dangers of alcohol abuse should not be underestimated. Personal responsibility and risk competence are the central aspects of a responsible approach to alcoholic beverages. The aim must therefore be to implement a policy oriented towards the causes of alcohol abuse. This requires an open and fact-based dialogue between all socially relevant groups. The members of BSI have been facing up to their responsibility through various institutions for decades.

The **responsible consumption** of alcoholic beverages is not the problem, but the **abuse of the products**. The majority of consumers - around 90% - deal responsibly and competently with alcoholic beverages in Germany.

The members of the **BSI** have been supporting the "**Arbeitskreis Alkohol und Verantwortung**" ("Working Group on Alcohol and Responsibility") since 2005, which was set up on the basis of the BSI's policy paper. Since then, the committee has been dealing with the so-called "non-commercial" tasks of the BSI in order to promote the responsible consumption of alcoholic beverages and the reduction of abusive consumption.



These goals are achieved through preventive education and information measures as well as effective self-regulation by BSI member companies. Indirectly, all BSI member companies support the “Arbeitskreis Alkohol und Verantwortung” (“Working Group on Alcohol and Responsibility”), whose prevention measures are developed by various independent scientific experts, because an effective alcohol policy must also address the **causes** of abuse, rather than merely “fighting” the symptoms.

With regard to the **requirements in the WHO's “Global strategy to reduce the harmful use of alcohol”**, we may make the following comments, among others:

- **Alcohol consumption, alcohol abuse:**

Per capita consumption of alcoholic beverages and harmful use of alcohol are brought together in the new WHO document, which is in obvious contradiction with the title and the strategy itself.

However, a clear distinction should be made between “**responsible consumption**” (at least 90% of people aged 16 and over in Germany practice this) and “**abuse**” in a comprehensive way. The “Arbeitskreis Alkohol und Verantwortung” (“Working Group on Alcohol and Responsibility”) of the BSI in Germany has been dealing with these issues for 15 years.

Moreover, the consumption of alcoholic beverages has declined by a total of 12.7 litres of finished goods per capita or 0.6 litres pure alcohol per capita between 2008 and 2019. Germany is **not** one of the world champions in spirits drinking - as the following overview of spirits consumption in Europe in 2018 according to the IWSR analysis will show you.

Spirituosenkonsum in Europa 2018			
(Angaben in Liter Fertigware pro Kopf der Bevölkerung)			
Land	Konsum pro Kopf	Land	Konsum pro Kopf
1. Russische Föderation	13,2	23. Irland ¹⁾	4,3
2. Lettland ¹⁾	11,5	24. Georgien	4,2
3. Bulgarien ¹⁾	11,3	25. Finnland ¹⁾	4,1
4. Belarus	10,9	26. Kroatien ¹⁾	3,9
5. Litauen ¹⁾	10,0	27. Dänemark ¹⁾	3,9
6. Estland ¹⁾	10,0	28. Spanien ¹⁾	3,8
7. Slowakische Republik ¹⁾	8,6	29. Albanien	3,7
8. Ukraine	8,3	30. Niederlande ¹⁾	3,3
9. Polen ¹⁾	7,5	31. Griechenland ¹⁾	3,3
10. Montenegro	7,0	32. Belgien/Luxemburg ¹⁾³⁾	3,3
11. Serbien	7,0	33. Österreich ¹⁾	3,2
12. Moldawien	6,8	34. Schweiz	2,7
13. Tschechische Republik ¹⁾	6,3	35. Slowenien ¹⁾	2,4
14. Kasachstan	5,9	36. Portugal ¹⁾	2,3
15. Malta ¹⁾	5,8	37. Norwegen	2,3
16. Ungarn ¹⁾	5,5	38. Schweden ¹⁾	2,2
17. Armenien	5,5	39. Italien ¹⁾	2,0
18. Frankreich ¹⁾	5,1	40. Kosovo	1,9
19. Rumänien ¹⁾	5,1	41. Island	1,9
20. BR Deutschland¹⁾²⁾	5,1	42. Bosnien und Herzegowina	1,5
21. Vereinigtes Königreich ¹⁾	4,7	43. Aserbaidschan	1,4
22. Zypern ¹⁾	4,6	44. Türkei	0,8

¹⁾ Länder der Europäischen Union

²⁾ Analyse des ifo Instituts – Leibniz-Institut für Wirtschaftsforschung an der Universität München: Pro-Kopf-Verbrauch für Spirituosen 2018: 5,4 Liter Fertigware – vgl. Seite 10

³⁾ Einschließlich Grenzverkehr

Quelle: the IWSR and the IWSR Magazine (the Source for Wine & Spirits Analysis)

Restrictive measures, which are exclusively oriented towards a general reduction of the per capita consumption of alcoholic beverages, do not reduce alcohol abuse, but rather stigmatise the consumer as not sufficiently competent. The **average overall consumption** does not tell us anything about consumption patterns:

The same quantity of alcoholic beverages can be consumed responsibly over several days a week or consumed abusively when drinking. The average is the same and therefore not meaningful. If the majority of the population who now enjoy alcoholic beverages responsibly drinks less, little is gained in terms of health policy. More effective than bans are measures to strengthen risk competence and concrete offers of help for those who have problems in dealing responsibly with alcoholic beverages.

- **Advertising:**

In Germany, the “**Voluntary commitments on commercial communication with alcoholic beverages**” of the German Advertising Federation (Zentralverband der deutschen Werbewirtschaft e. V. - ZAW) have been in place for 40 years now, which the BSI and its member companies have to comply with comprehensively and go even further. Thus, the special protection of young people in advertising and marketing is strictly adhered to. However, further dirigistic interventions in the market are rejected, as information about new and existing products on the market will continue to be necessary in the future. Experience abroad also shows that advertising restrictions and bans do not lead to a reduction in consumption of alcoholic beverages. As self-regulation in Germany - especially in connection with children and the protection of young people - is very effective, it will continue to be pursued as an effective measure.

With regard to **advertising restrictions**, there is no causal link between advertising and abusive alcohol consumption - various scientific studies confirm the lack of causality. There is therefore no scientifically conclusive evidence of the effectiveness of advertising restrictions in reducing abuse.

Advertising/Gap between advertising expenditure and overall consumption:

Despite steadily increasing advertising expenditure, overall consumption has been on a downward trend for many years. Advertising is an instrument for gaining and maintaining market share in a market that has been declining for years and does not lead to an increase in total consumption.

- **Alcohol abuse by young people:**

For several years now, the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung - **BZgA**) together with the **Federal Ministry of Health** in Germany has been publishing that “binge drinking” by children and young people is in decrease in the last 8 years. The latest press releases are attached as Annexes 1 to 3 for your information: This shows that comprehensive **educational measures** are working.

In this context, we would also like to point out the valuable prevention measures of the “**Arbeitskreis Alkohol und Verantwortung**” (“Working Group on Alcohol and Responsibility”) through the evaluated prevention initiative “**Klartext reden!**” which is supported by the Federal Drug Commissioner in Germany.

Years ago, the WHO also reported that misuse among young people is declining (cf. press release as Annex 4).

- **Intervention in pricing:**

Any political demand for excise tax increases is based on the allegation that lower affordability of alcohol would lead to lower consumption. However, this is not the case in most countries. In some cases, **substitution** with other or **cheaper products** is taking place. **Illicit alcohol** and smuggling may also be involved.

Moreover, **price increases** only affect consumers who use alcoholic beverages responsibly. The question is to what extent consumers who do not use alcoholic beverages responsibly will behave - they will certainly accept the price increase or will often switch to substitutes – for example from the pharmaceuticals sector. This can surely not be the intention.

There are a number of **countries in Europe** which show that tax increases have not led to the desired result: A look at Scandinavian countries, for example, shows that the prices of alcoholic beverages are kept extremely high by state intervention, but consumption has not always decreased by this.

The increase in the price of alcoholic beverages is not suitable for reducing **abusive consumption**. Harmful consumption patterns also exist in countries with significantly higher prices (Scandinavia). There is no scientifically conclusive evidence of the effectiveness of tax increases in reducing abusive consumption. Price increases lead to **evasive market movements** towards less heavily taxed products or to “smuggling” etc. Moreover, such measures impose an unfair burden on citizens who consume in a moderate and responsible manner.

- **Restriction of availability:**

Measures aimed at **restricting the availability of alcoholic beverages** miss the objective of combating abuse. Prohibitions do not act as a deterrent, especially for young people, but rather as an even greater attraction. One looks for bypassing and alternative channels. Such measures therefore partly shift the problem into the private sphere, without any possibility of social control. After all, anyone who wants to abuse alcoholic beverages as intoxicants or addictive substances will always find ways and means of obtaining them. Moreover, there is no clear evidence of the effectiveness of sales restrictions in terms of reducing abuse.

Here in Germany, the **Youth Protection Act** applies, which prohibits the sale of beer and wine to children and young people under the age of 16 and of spirits and mixed drinks with spirits to people under the age of 18. The members of our association adhere to this regulation without any ifs and buts.

In this context, the BSI appeals to the enforcement of the control.

In addition, the “**Schulungsinitiative Jugendschutz**” (“Initiative on training in the protection of minors”) of the “**Arbeitskreis Alkohol und Verantwortung**” (“Working Group on Alcohol and Responsibility”) provides information on compliance with the Youth Protection Act with regard to alcoholic beverages at the bar, in shops, in online trading and in the catering trade and at petrol stations, i.e. no sale of alcoholic beverages to persons under 18 years of age - at least not of spirits and mixed drinks containing spirits. According to a web-based training course (<https://schuju-training.de>), 200,000 employees in Germany have already

participated in this with extensive cooperation, which also shows that self-regulation and prevention are effective.

This prevention measure has been very successful and will be further expanded and evaluated.

- **Warnings:**

With regard to “warning labels”, evaluations of various countries show that warning labels do not lead to the desired results and therefore a withdrawal of the legal basis is sometimes discussed.

- **Conclusion:**

Independently of this discussion, the BSI - as already mentioned - has for over 15 years launched comprehensive prevention measures in Germany within the framework of the activities of the “Arbeitskreis Alkohol und Verantwortung” (“Working Group on Alcohol and Responsibility”), which inform consumers and have a particular impact on the issues:

- **“Klartext reden!”** (“Tell it straight!”) - Initiative to support alcohol prevention in families,
- **“Schulungsinitiative Jugendschutz”** (“Initiative on training in the protection of minors”) - initiative for the consistent implementation of the Youth Protection Act,
- **“Verantwortung von Anfang an!”** (“Responsible from the Start!”) - Initiative for abstaining from alcoholic beverages during pregnancy and nursing,
- **“Hinsehen, Zuhören, Ansprechen!”** (“Look, Listen, Talk!”) - Alcohol in the Workplace – Guidance for helping co-workers,
- **“DON'T DRINK AND DRIVE”**.

These initiatives are also helping to ensure that more and more people in Germany deal responsibly with alcoholic beverages. This is shown by relevant **evaluations**. The measures are mainly networked with a large number of external **scientists**, but also with the Federal Drug Commissioner in Germany.

Comprehensive preventive measures to educate people will remain important in the future, in addition to the existing laws - because: Education and personal responsibility are mutually dependent.

We thank WHO for considering our issues in our presentations.

Burundi alcohol Policy Alliance

Country/Location: Burundi

Submission

The implementation of the Global strategy will help a lot on having a guideline on national level to reduce the harmful use of alcohol which is increasing day by day

Attachment(s): 0

CADCA

Department/Unit: *International*

Country/Location: United States of America

Submission

CADCA fully supports the WHO efforts to reduce the harmful use of alcohol and we are please to provide our comments as part of the web based consultation on the working document. Key points covered throughout our submission for each of the action areas and guiding principles include importance of local level policy interventions and prioritizing measures to protect children and adolescence.

Attachment(s): 1

00505_26_cadca-comments-who-working-document-on-alcohol.pdf

CADCA Comments on WHO Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Community Anti-Drug Coalitions of America (CADCA) is a civil society organization that represents over 5,000 community coalitions across the United States and in 30 countries around the world. CADCA engages individuals from key sectors including schools, law enforcement, youth, parents, healthcare, media, the faith community, and others. It also supports the World Health Organization's (WHO) action plan and its Global Strategy to Reduce the Harmful Use of Alcohol.

The prevention of substance use and misuse before it starts is the most effective and cost-efficient way to reduce substance use and its associated costs. Every dollar invested in prevention saves communities between \$2.00 and \$20.00.¹ CADCA and the community coalitions it represents understand the dangers of underage drinking and the harms of excessive alcohol use.

CADCA commends the WHO's commitment to a multi-sector approach for addressing underage drinking and fully supports the WHO's efforts to reduce excessive alcohol consumption. The WHO's high-impact SAFER initiative emphasizes banning or comprehensively restricting alcohol advertising. This effort will help prevent the initiation of drinking among underage youth and raise the age of initiation for alcohol use, a prevention strategy that has been proven effective. A multi-sector approach with committed leadership and involvement of all areas of a community will help mitigate the effects of excessive alcohol consumption.

CADCA values the WHO for its goal of having Member States advocate for high-impact interventions, strategies, and other actions to prevent and reduce alcohol-related harms, especially among at-risk populations. Additionally, CADCA supports WHO efforts to increase awareness of the health risks of underage drinking and excessive alcohol consumption in Member States. These goals will help save lives and promote public health.

CADCA supports the purpose, vision, objectives, key components, target areas for policy measures and guiding principles outlined in Boxes 1 – 5 of the WHO action plan. Improving health and social outcomes for individuals, families and communities due to the harmful use of alcohol is a mutual goal of the organization. Within this context, CADCA recommends the following suggestions. In Box 5 for guiding principles, we would recommend expanding on principle 2 and include that “policies should be equitable and sensitive to national, religious, cultural context *and focus on doing no further harm to marginalized communities.*” We also propose including language in the guiding principles which places emphasis on upstream policy solutions to protect children and adolescents from commercial access and availability while shifting the burden away from youth to retailers and industry.

CADCA also offers additional recommendations for the action areas outlined in the action plan as it relates to the role of international partners and non-state actors.

ACTION AREA 1: IMPLEMENTATION OF HIGH IMPACT STRATEGIES AND INTERVENTIONS.

Communities play an important role in the implementation of high impact strategies and interventions at the local level. Decision makers, stakeholders and sector representatives can work collectively to pass policies and put comprehensive regulatory structures in place as described in the SAFER Initiative.

¹ Swisher, J.D., Scherer, J.M. Yin, R.K. (2004 October). Cost-benefit estimates in prevention research. *The Journal of Primary Prevention*, Vol. 25(2), pp. 137-148.

Therefore, for Action 2 under “Member States and non-state actors, we recommend refining the policy menu to not only include a complement of broad policy ideas but also the implementation of strategies such as licensing systems, establishing and enforcing minimum age, prohibiting drinking in public spaces, alcohol outlet density, limiting and enforcing days and hours of sale, etc.

ACTION AREA 2: ADVOCACY, AWARENESS AND COMMITMENT

Under action 2 for non – state actors, we recommend that sector representatives, civil society organizations and institutions develop comprehensive campaigns that communicate the need to decision makers in support of specific policies and call to action for the public. Avoiding mass media campaigns to simply raise awareness about harms can be expensive, difficult to measure impact and lead to unintended outcomes.

ACTION AREA 3: PARTNERSHIP, DIALOGUE AND COORDINATION

Under action 2 for non – state actors, we recognize that to have a successful “whole of society approach” on alcohol policy and implementation it is imperative to include partnerships, dialogue, and collaboration from national, regional, and local level. For civil society engagement at the local level, we recommend establishing community coalitions. We define community coalitions as “a formal arrangement for collaboration among groups or sectors of a community”, in which each group retains its identity, but all agree to work together toward the common goal to improve health and social outcomes at the community-level. By leveraging residents and sector representatives who have a genuine voice in determining the best strategies to address local alcohol problems, we effectively engage businesses, parents, media, law enforcement, schools, faith organizations, health providers, social service agencies, and government – to collaborate and develop plans, policies, and strategies to achieve reductions in alcohol use among youth and over time in adults.

ACTION AREA 4: TECHNICAL SUPPORT AND CAPACITY-BUILDING

Under action 2, civil society organization are encouraged to build capacity at the national and international level. We would suggest a further look at the role municipalities and local administrative units play in serving as laboratories of policy innovation while recognizing that they also require the necessary capacity and infrastructure to achieve population level changes when it comes to harmful alcohol use. We recommend implementing the following framework for localities to develop the necessary infrastructure to address the harmful use of alcohol: 1) assess prevention and treatment needs based on epidemiological data¹; 2) build prevention and treatment capacity; 3) develop a strategic plan²; 4) implement effective treatment programs, community prevention policies and practices³; and 5) evaluate efforts for outcomes⁴. The strength of this comprehensive approach is that it not only identifies the challenges, problems, and gaps of a community, but it also highlights assets and resources. By allowing a community to plan, implement and evaluate its efforts across all community sectors solutions become relevant to the settings of individuals, families, schools, workplaces and the community at large.

¹ Butterfoss, F.D. (2007). *Coalitions and partnerships for community health*. San Francisco, CA: Jossey-Bass.

² Collie-Akers VL, Fawcett SB, Schultz JA, Carson V, Cyprus J, Pierle JE. (July 2007). Analyzing a community-based coalition’s efforts to reduce health disparities and the risk for chronic disease in Kansas City, Missouri. *Preventing Chronic Disease* [serial online]. 2007 Jul. Available from http://www.cdc.gov/pcd/issues/2007/jul/06_0101.htm. Hays, C.E., Hays, S.P., DeVille, J.O., & Mulhall, P.F. (2000). Capacity for effectiveness: The relationship between coalition structure and community impact. *Evaluation and Program Planning*, 23, 373-379.

³ Foster-Fishman, P.G., Berkowitz, S.L., Lounsbury, D.W., Jacobson, S., & Allen, N.A. (2001). Building collaborative capacity in community coalitions: A review and integrative framework. *American Journal of Community Psychology*, 29(2), 241-261.

⁴ KU Work Group for Community Health and Development. (2007). *Use Promising Approaches: Implementing Best Processes for Community Change and Improvement*. Lawrence, KS: University of Kansas. Retrieved November 12, 2008, from the World Wide Web: <http://ctb.ku.edu/en/promisingapproach/>. Roussos, S.T. & Fawcett, S.B. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health*, 21, 369-402.

ACTION AREA 5: KNOWLEDGE PRODUCTION AND INFORMATION SYSTEMS

For this action area we recommend that Member State increase focus and generate data that includes indicators on delaying the age of first use of alcohol worldwide and encourage Member States to develop a way to track this metric. We also suggest that Member States track past 30-day use of alcohol by children and adolescents. The inclusion of these metrics is essential given that the younger and more frequently adolescents consume alcohol the more likely they are to develop alcohol use disorder later in life. These types of metrics are important to for civil society to further advocacy for implementation of alcohol policy measures to protect children and adolescents.

As the world deals with the COVID-19 pandemic, the WHO Global Strategy to Reduce the Harmful Use of Alcohol is needed now, more than ever before. CADCA fully supports efforts to prevent alcohol retailers from advertising to youth, and multi-sector strategies to prevent and reduce excessive alcohol consumption.

California Alcohol Policy Alliance

Country/Location: United States of America

URL: <https://alcoholpolicyalliance.org/>

Submission

In accordance with the alcohol harm prevention priorities of the California Alcohol Policy Alliance (CAPA), we offer the following suggestions to improve the WHO Global Strategy to Reduce the Harmful Use of Alcohol.

1. An emphasis on Charge For Harm (price controls through taxes which in turn fund prevention and treatment) as a mitigation strategy.
2. Enhanced monitoring and counter-marketing in response to alcohol industry advertising, as well as dangerous products.
3. Greater emphasis on alcohol packaging health labels.
4. A more explicit of health equity, economic justice, and social justice concepts, oriented both to vulnerable communities within member states and the lower- and middle-income countries within the WHO membership.
5. An acknowledgment that alcohol control requires enforcement, and that within that effort an effort should be made to not allow alcohol control to become a vehicle to perpetuate bias and inequality.

They are elucidated in the attached.

Attachment(s): 1

00512_30_capa-global-initiative-comments.pdf



California Alcohol Policy Alliance

December 10, 2020

World Health Organization
Department of Mental Health and Substance Use
20, Avenue Appia
CH-1211 Geneva 27, Switzerland

RE: Comments on the draft WHO Global Strategy to Reduce the Harmful Use of Alcohol

To whom it may concern,

The California Alcohol Policy Alliance (CAPA) is a coalition of public health and safety advocacy organizations working to promote healthy alcohol policy in the state of California within the United States of America. California is the most populous state in the United States, as well as a major economic driver for the nation. California by itself would be the fifth-largest economy in the world. Needless to say, the state is also both the leading producer and consumer of alcohol in the United States. This makes CAPA's goals, strategies, and impact equivalent to that of a national-level coalition.

As such, we would like to respond the WHO request for comment on the Global Strategy to Reduce the Harmful Use of Alcohol. The request for comment asks that we address the following prompt:

“We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration:”

We appreciate the care and breadth put into the recommendations, but would like to make the following suggestions based on our own areas of concern.

Area 1: Implementation of High-Impact Strategies and Interventions

- Price controls are a major component of the WHO SAFER initiative, and we appreciate the emphasis placed upon them in the action plan. However, we strongly maintain that the funding raised through alcohol taxes should be dedicated to programs addressing prevention of, treatment for, and recovery from alcohol harm. This “Charge for Harm” model should be more explicitly advocated for by the Secretariat.

We also strongly believe the alcohol industry uses marketing, political influence, and economic power to push back against the implementation of most SAFER initiative items in general, and alcohol taxes in particular. Action 3 for non-state actors should strengthen the language against interfering in the development of public health members, and member states should be urged to embrace a more adversarial stance.

[AlcoholPolicyAlliance.org](https://www.alcoholpolicyalliance.org)

A Project of Alcohol Justice

Mayra Jimenez, Advocacy Manager | 323-683-4687 |
mayraj@alcoholjustice.org





California Alcohol Policy Alliance

Lastly, the introductory language assumes universal health care as a feature of member states. This is clearly not true of the United States (though, granted, the United States also seems reluctant to be a member state). It is not true of many developing economies, as well. A truly global alcohol harm prevention strategy must embrace alternate methods to provide preventive and palliative care. Charge For Harm can fill this gap.

- We recognize that advertising restrictions are part of the SAFER initiative. Nonetheless, non-State actor Action 3 encourages the industry to embrace their role as “marketers”.
- SAFER fails to address a major international goal, one shared by CAPA, namely reforming alcohol labelling laws both in terms of content and presentation, and making them a universal feature of alcohol packaging. If this is not added to SAFER, it should be at least mentioned within the Area 1 preamble.

Area 2: Advocacy, Awareness, and Commitment

- Alcohol advertising is a major route for a number of alcohol harms, including but not limited to targeting of youth, sexual and gender minority groups, and racial and ethnic minority groups. Communication strategies for member states should not be limited to harms and awareness; they must also include media literacy and counter-marketing, both as national campaigns and as educational curricula. The Secretariat and non-State groups also play key roles in monitoring and flagging new communications strategies or vulnerable groups. Action 3 for non-State groups should also condemn the industry for targeting communities that are extraordinarily vulnerable to negative consequences from alcohol use.

This also suggests that the scope of non-State actors in Action 2 (for this and all subsequent items) is too vague. It should include human rights organizations, organizations that advocate for the wellness and self-determination of vulnerable communities, and organizations that advocate for the health of LGBTQ+ communities.

- Action 3 for non-State groups states that the industry should not promote fraudulent claims of health or safety regarding their products. This should be expanded to enjoin the alcohol industry not to engage in demonstrably ineffective or counterproductive public awareness campaigns (such as “Enjoy Responsibly”).
- Specific products (including alcopops, powdered alcohol, and likely hard seltzers) are notably youth-targeted and/or prone to promote dangerous overconsumption. Action items directed at both Member States and the Secretariat could be honed to reflect the need to restrict the availability of these products.
- Member state Action 7 calls for labelling requirements for alcohol packaging. It should be emphasized that these requirements follow best practices in terms of both content and form. Legibility, size (percent of packaging area), and graphical elements to augment text are all considered significant enhancements to the impact of warning and information labels. Note also that there is a growing trend in the United States for alcohol companies to use caloric value and ingredient transparency to positively market their products—there are many instances where insisting on their inclusion is useless if not an actual boon to the industry.



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Area 3: Partnership, Dialogue, and Coordination

- Marketing and advertising, especially in the age of social media, is often transnational and requires a transnational approach to bring into compliance with SAFER. This could be incorporated into Secretariat Action 3.
- Much alcohol advertising occurs on government-owned property (e.g., public transit stations, stadiums, etc.). The alcohol industry, in non-State Action 3, should not just be urged not to interfere with alcohol policy and development, they should be strongly urged not to build economic partnerships with governments. Likewise, an action items should ask Member States to end these partnerships.
- As above, the Secretariat should make sure to include local groups that advocate for vulnerable communities, including racial and ethnic minorities and LGBTQ+ residents. These voices are essential to partnership formation, to promote health equity, to ensure a culturally competent range of perspectives on the determinants of alcohol harm, and to maintain a social-ecological perspective on the impacts of alcohol.
- Not only are the harms from alcohol distributed unequally, so are the consequences of alcohol law enforcement. The Secretariat should work with Member States to support racial, ethnic, socioeconomic, and health justice in all advocacy.

Area 4: Technical Support and Capacity-Building

- The enforcement of alcohol-related laws is a necessary backstop for effective regulation. It is not clear that every member state has equivalent resources invested in development of effective alcohol control departments. This extends also to LMICs and LICs. Experience shows that insufficient alcohol controls in one country can create alcohol harm in adjacent ones. Experience also shows that, given the chance, the alcohol industry will wield influence to dilute the scope and effectiveness of alcohol control enforcement. Therefore, the Secretariat should also be working to develop a framework for effective enforcement, including funding and accountability mechanisms. HMIC and HIC Member States should be prepared to lend expertise and resources to emerging economies.

The flipside of this is, as indicated above, inequitable enforcement. Again, the Secretariat and Member States should be ready to advise and support in implementing alcohol control enforcement in a just manner.

Lastly, non-State Action 3 should proactively identify enforcement structures as an area in which the industry is unwelcome to lend support.

- One of the more promising developments of this century is the increasing acceptance of harm reduction models. This should be reflected in the assistance and capacity building actions of the Secretariat, ensuring that alcohol control and enforcement is directed at corporations and other economic entities, and deemphasizing criminalization and the need to incarcerate or sanction individuals.



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Area 5: Knowledge Production and Information Systems

- Alcohol advertising is a constantly evolving art, and the gap between the introduction of a new campaign and the development of counter-marketing gives rise to harmful use expectations and norms. Both the Secretariat and Member States should be engaged in the monitoring of alcohol advertising materials, strategies, and channels, and disseminating that information to Member States and NGOs. In non-State Action 3, the industry should be expected to share its plans for advertising campaigns.
- We applaud the inclusion of Action 7 and the explicit inclusion of LICs and MICs. We want to emphasize, however, the diasporas of these countries are also prone to targeting, inordinately severe consequences, and difficulty accessing services. An action items should be inserted for Member States to engage in both surveillance and retroactive analysis of the disparate impacts of alcohol harm on racial, ethnic, and sexual and gender minorities. This should include evaluate both the impact of alcohol and barriers to treatment and recovery. The Secretariat should be prepared to collect and summarize this surveillance.

(As a technical note, this surveillance should be from two frames: 1. group health and epidemiology, and 2. the disparate impacts of specific producers and/or products.)

- As the call for effective labelling grows, the Secretariat should be monitoring the appearance of these new alcohol health labels with an eye to generating and disseminating a definitive best practice.
- Member States should be monitoring how alcohol control enforcement affects various communities, including racial, ethnic, and sexual and gender minority groups. Moreover, non-State NGOs and community groups working with indigenous communities, racial and ethnic minorities, and/or LGBTQ+ residents should be encouraged and trained to collect, analyze, and disseminate alcohol harm data regarding the communities they serve.
- The Secretariat should be prepared to identify states that are not demonstrating a commitment to health equity, enforcement equity, and racial justice in both services access and enforcement outcomes. More broadly, there should be an effort to scorecard member states' alcohol policy environments against the goals put out in SAFER and other global strategy benchmarks.

From a purely self-interested perspective, we especially urge the WHO to publicly identify the failings of the United States.

Area 6: Resource Mobilization

- We appreciate that Member State Action 2 reflects the Charge For Harm strategy we outline above. However, we feel it is more than a resource mobilization technique, since it has both direct (price control) and indirect (funding prevention and health education) effects on consumption levels.



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- We also strongly support Action 4, but emphasize that the vulnerable diasporas, indigenous communities, and sexual and gender minority communities within Member States often need specific support and resources as well. In many cases, membership and challenges for these groups cross-national boundaries, thus requiring a commitment from multiple states. And as above, the documents should clearly include organizations advocating for those groups in non-State Action 2.

In addition, as above, the startup of effective alcohol enforcement in MICs and LICs may require resource mobilization on behalf of other member states. Likewise, criminalization may be a tempting strategy for MICs and LICs, and it may require additional resourcing to ensure enforcement systems favor targeting producers and retailers over individuals.

- So many of the strategies needed for effective treatment and recovery assume universal healthcare, and the document does as well in several locations. The document should err on the prescriptive in this case, identifying universal health—or at least universal access to treatment and recovery—as an essential component of effective global alcohol control.

By and large, this document is an ambitious and promising step along the path to a global framework on alcohol control. We look forward to seeing the final version of this document, and thank you for the opportunity to collaborate on it.

Respectfully

Veronica de Lara
Cochair, California Alcohol Policy Alliance,
California, United States of America

Gilbert Mora
Cochair, California Alcohol Policy Alliance,
California, United States of America

Cámara de Comercio de Lima

Department/Unit: *Gremio de Importadores y Distribuidores de Vinos y Licores de la Cámara de Comercio de Lima*

Country/Location: Peru

Submission

Mensaje 1: instamos a la OMS a reconocer toda la gama de opciones normativas incluidas en la Estrategia Global que promueven alternativas para atender el consumo excesivo de alcohol y no únicamente SAFER, o que al contrario prioricen esa frente a otras opciones.

Mensaje 2: La Estrategia Global menciona de manera exclusiva, a que las acciones deben estar enfocadas en la reducción del consumo nocivo. Al contrario, aclaramos que no deben hacerse recomendaciones en el plan de acción que estén enfocadas en la reducción del consumo en general.

Mensaje 3: El sector privado juega un papel fundamental en el desarrollo de políticas públicas y además acciones que pueden contribuir a eliminar el consumo nocivo de alcohol y sus consecuencias.

Todas las empresas que conformamos este gremio nos suscribimos a la obligación de evitar el consumo excesivo y nocivo de alcohol, buscando educar a jóvenes, padres y maestros sobre los riesgos del consumo de alcohol en menores de edad, además educando sobre los riesgos beber y conducir y siempre promoviendo mensajes de moderación a través de todas nuestras emblemáticas marcas en todo el mundo.

Nos despedimos poniéndonos a la orden para participar en trabajos conjunto entre el sector público y privado y agradeciendo de antemano la apertura para introducir nuestros comentarios.

Attachment(s): 1

00499_23_respuesta-consulta-pública-oms-gremio-de-licores-perú.pdf

9 de diciembre 2020

Atención: Representantes Organización Mundial de la Salud;

En referencia a: Consulta en línea realizada por la OMS (Organización Mundial de la Salud) sobre el Proyecto de Plan de Acción para la Implementación de la Estrategia Global para reducir el consumo nocivo de alcohol;

Respuesta de parte del gremio de importadores y distribuidores de Perú conformado por las siguientes empresas: Pernod Ricard, Campari, Diageo, Backus, Cartavio Rum Company, Drokasa Licores, Perufarma & LC Group.

El siguiente documento resume las apreciaciones y comentarios del *Gremio de Importadores y Distribuidores de Vinos y Licores de la Cámara de Comercio de Lima* con respecto al documento de trabajo para el desarrollo de un plan de acción para fortalecer la implementación de la Estrategia Global para reducir el consumo nocivo de alcohol.

Iniciamos nuestra carta reconociendo la importancia que representan las acciones planteadas en el documento de trabajo que establece un proyecto de plan de acción, e indicaciones claras de los objetivos de la OMS. Nuestra asociación manifiesta su constante apoyo a promover la educación y la conciencia del público en general y fortalecer las actividades de prevención.

Partimos con señalar que la Estrategia Global debe seguir siendo la principal política en materia de alcohol y que todos los actores del sector público y privado, incluida la OMS debe enfocarse en mejorar su implementación. El documento en consulta establece los objetivos operativos propuestos del plan de acción 2022-2030 y las áreas de acción propuestas se basan en los objetivos de la Estrategia global y los cuatro componentes clave de acción para reducir eficazmente el uso nocivo de alcohol. Sin embargo, nos preocupa que claramente señalan que estos últimos no son idénticos a los de la Estrategia global. Esto menoscaba los compromisos asumidos a través de la resolución EV146(14) de la Junta Directiva (EB), en la que los Estados Miembros acordaron que la Estrategia Global debe seguir siendo la principal política en materia de alcohol.

En base a esto destacamos los siguientes puntos:

Mensaje 1: instamos a la OMS a reconocer toda la gama de opciones normativas incluidas en la Estrategia Global que promueven alternativas para atender el consumo excesivo de alcohol y no únicamente SAFER, o que al contrario prioricen esa frente a otras opciones.

En el caso específico de Perú, un uso exclusivo de SAFER como estrategia para atender esta problemática puede derivar en consecuencias de salud pública mucho más peligrosas, más aún durante una coyuntura como la que se ha generado raíz de la pandemia. Nos referimos específicamente sobre los puntos (i) Reforzar las restricciones sobre la disponibilidad de alcohol y (iv) Aumentar los precios del alcohol mediante impuestos especiales y otras políticas de precios de SAFER.

De acuerdo con el más reciente estudio de Euromonitor¹, el tamaño del mercado de bebidas alcohólicas ilegales en Perú se estima en más de un 30% del total del mercado de bebidas alcohólicas.

Los altos impuestos generan un alza en los precios de las bebidas lo cual es uno de los principales factores que promueven el crecimiento de este mercado ilegal. El aumento de impuestos no necesariamente conduce a menor consumo, sino a que los consumidores sustituyen las formales por informales, en cuyo caso aquellas provenientes del contrabando reducen el recaudo y las adulteradas se vuelven un riesgo para la salud.

Con base a este mismo punto, destacamos además que según varios estudios², cualquier aumento en los impuestos causaría un efecto opuesto al objetivo del gobierno: el aumento de los precios minoristas impulsará una migración del consumo de productos lícitos a productos ilícitos que reducirá la base imponible total, lo que generará menores ingresos para el gobierno.

Finalmente, y con el objetivo de ahondar sobre este punto mostramos data un ejemplo práctico. Efectivamente existe una relación directa entre los niveles de alcoholes ilícitos y los niveles impositivos. La raíz de este efecto se encuentra en el arbitraje existente entre los costos de producción y logística y los precios al consumidor en el mercado. Cuanto mayores son los impuestos, mayor es el espacio de arbitraje que es utilizado por los operadores ilícitos, esto se demostro en un análisis que realizó la consultora APOYO Consultoría en Perú, a raíz del incremento al impuesto sobre el consumo que se llevó a cabo en el 2013. Destacamos que hubo dos incrementos adicionales, uno en el 2018 a todas las categorías que pagan ISC (Impuesto Selectivo al Consumo) y uno adicional a la categoría de cerveza en el 2019.

Los ingresos de los contrabandistas se habrían incrementado en 4% después del aumento del ISC en mayo del 2013.

- A continuación, se muestra un ejemplo típico para licores de 40°:

Brecha de ingresos de los contrabandistas			
Tipo	Unidad	SUNAT	
		Antes del cambio de ISC	Después del cambio de ISC
Precio promedio antes de impuestos 1/	Soles por litro	43.7	43.7
Impuesto Selectivo al Consumo	Soles por litro	8.7	10.9
IGV	Soles por litro	9.4	9.8
Precio final	Soles por litro	61.9	64.5
Cantidad de contrabando	LAE mm	2.0	2.0
Cantidad de contrabando	Litros mm	5.0	5.0
Ingresos contrabandista	Soles mm	309.2	322.1

1/ Precio promedio entre mayo de 2013 y mayo 2014 (incluye ron, vodka, whisky y otros).

Fuente: Apoyo Consultoría, Sunat.

Elaboración: APOYO Consultoría

Mensaje 2: La Estrategia Global menciona de manera exclusiva, a que las acciones deben estar enfocadas en la reducción del consumo nocivo. Al contrario, aclaramos que no deben hacerse recomendaciones en el plan de acción que estén enfocadas en la reducción del consumo en general.

¹ Euromonitor International, Mercado De Bebidas Alcohólicas Ilegales En Colombia, Ecuador Y Perú, publicado en

² IARD, Taxation of beverage alcohol, last reviewed in April 2018, <http://www.iard.org/wp-content/uploads/2016/01/PR-Taxation.pdf>

El documento en consulta presenta una amplia cantidad de ejemplos en donde se señalan mejoras en las tendencias de consumo excesivo, demostrando con ejemplos claros, la efectividad que tiene la concientización y educación en los daños que generan el consumo nocivo de alcohol. Este documento incluso evidencia que dicho consumo ha disminuido en grupos de personas jóvenes. El plan de acción debe enfocarse en construir sobre estas acciones, y acelerar dichas tendencias y resolver los espacios en los que no se ha tenido avance. Desde nuestra asociación quisiéramos destacar el esfuerzo de uno de nuestros asociados en educar sobre el efecto del consumo de alcohol en menores a través de su programa “La Bomba” liderado por Diageo junto con el Dirección Regional de Educación de Lima Metropolitana, del Ministerio de Educación. El objetivo de esta iniciativa es principalmente abordar los daños, causas y consecuencias del consumo de alcohol en menores de edad. Su objetivo sin embargo trasciende la edad de los chicos pues se convierten en adultos informados y conscientes sobre el efecto del consumo nocivo de alcohol en general. El éxito del programa se basa justamente en que se trabaja sobre una iniciativa cuyos resultados han sido exitosos y se busca fomentar y mejorar su alcance.

Desde el inicio del programa en el 2016 se han educado a más de 16mil estudiantes en la región de Lima Metropolitana. El objetivo es convertir esto en una iniciativa de toda la asociación la cual recibirá mayor recursos y por ende, generará mayor alcance, llegando a miles de niños y adolescentes del país.

Este último punto nos lleva al tercer mensaje que quisiéramos destacar.

Mensaje 3: El sector privado juega un papel fundamental en el desarrollo de políticas públicas y además acciones que pueden contribuir a eliminar el consumo nocivo de alcohol y sus consecuencias.

Toda la problemática que rodea el consumo problemático de alcohol en el Perú, desde el consumo de productos ilegales hasta el consumo excesivo, no es un problema menor y queremos llamar la atención de la OMS sobre la urgencia de trabajar de la mano con la industria para elaborar proyectos y generar propuestas que atiendan de manera eficaz la situación. Por ejemplo, mesas de trabajo conformadas por el sector público y privado para el desarrollo de esquemas impositivos que disminuyan los incentivos que favorecen únicamente a la industria ilegal y desarrollar acciones para la promoción del consumo responsable y en la educación del consumidor sobre los impactos del consumo abusivo de alcohol. Un consumidor educado estará en mejores condiciones de elegir productos que no pongan en riesgo su salud.

El sector privado incentiva y fomenta una cultura de consumo responsable como parte de un estilo de vida equilibrado en adultos. Todo el mercadeo que promovemos y las comunicaciones de las compañías que conforman nuestra asociación se rigen por códigos comerciales que se centran en la moderación. Asimismo, de forma voluntaria, nuestra asociación publicó un código de autorregulación que promueve estándares y principios claves para promover el consumo responsable. (Referirse al Anexo I adjunto).

Entre las prácticas que promovemos, empresas miembros de nuestra asociación, como Backus, con el objetivo de evitar la venta y consumo de bebidas alcohólicas por menores de edad, celebra el “Día Mundial del Consumo Responsable” y se une al movimiento para sensibilizar a consumidores, colaboradores y puntos de venta sobre la importancia de promover un #ConsumoInteligente de bebidas alcohólicas. Esto es una actividad que se lleva a cabo todos los años.

Asimismo, contamos con un comité que supervisa y sanciona prácticas y conductas violatorias de estos principios. Bajo este mismo orden ideas, destacamos que diversas de las empresas de nuestra asociación incluye, de forma voluntaria, logotipos de embarazo o mensajes equivalentes en los envases o etiquetas

de sus productos, con el objetivo de desincentivar su consumo por parte de mujeres embarazadas, y evitar el consumo en menores de edad y beber y conducir.

Finalmente, destacamos el enorme esfuerzo que hacemos todas las empresas representantes del gremio en promover mensajes de consumo responsable en todos los espacios donde se comercializan bebidas alcohólicas, como por ejemplo, a través de las capacitaciones que ofrecemos a los restaurantes y bares de todo el país con respecto al servicio responsable, las medidas correctas para la preparación de tragos, así como información general sobre el procesamiento del alcohol y tips de consumo responsable.

Todas las empresas que conformamos este gremio nos suscribimos a la obligación de evitar el consumo excesivo y nocivo de alcohol, buscando educar a jóvenes, padres y maestros sobre los riesgos del consumo de alcohol en menores de edad, además educando sobre los riesgos beber y conducir y siempre promoviendo mensajes de moderación a través de todas nuestras emblemáticas marcas en todo el mundo.

Nos despedimos poniéndonos a la orden para participar en trabajos conjunto entre el sector público y privado y agradeciendo de antemano la apertura para introducir nuestros comentarios.

CAMARA NACIONAL DE LA INDUSTRIA DE TRANSFORMACIÓN (CANACINTRA)

Department/Unit: RAMA 27 "BEBIDAS ALCOHÓLICAS" PERTENECE AL SECTOR DE ALIMENTOS, BEBIDAS Y TABACOS

Country/Location: Mexico

URL: www.canacindra.org.mx

Submission

AFIRMATIVO

Attachment(s): 1

00276_51_comentarios-canacindra-rama-27-plan-acción-implementación-estrategia-mundial-reducir-el-consumo-nocivo-alcohol.pdf

COMENTARIOS al documento de trabajo para el desarrollo de un Plan de Acción para fortalecer la implementación de la Estrategia Global para Reducir el Uso Nocivo de Alcohol)

El documento con el Proyecto de Plan de Acción para la implementación de la Estrategia Mundial para reducir consumo nocivo de Alcohol propuesto por la OMS parece tener un enfoque único que es el de impulsar exclusivamente la iniciativa SAFER, lo cual no permitiría que los países miembros de la OMS pudieran desarrollar medidas adecuadas para las problemáticas específicas que cada uno de ellos vive con respecto al consumo nocivo de alcohol.

Los países deben tener la oportunidad de generar políticas que combatan el consumo nocivo de alcohol que mejor se adapten a su realidad política, social y cultural; por lo que se debe garantizar que el Plan de Acción logre llevar la Estrategia Mundial para reducir consumo nocivo de Alcohol a la práctica mediante instrumentos que los estados miembros puedan desarrollar y acondicionar. Además, recordamos que el Plan de Acción debe combatir el consumo nocivo del alcohol y no el consumo *per se*; y debe reconocer las contribuciones que hacen los distintos organismos privados, en la mayoría de las ocasiones de la mano de los gobiernos locales, en este sentido.

Instamos a la OMS al desarrollo del Plan de Acción que esté ligado a la Estrategia Global para reducir el consumo nocivo de alcohol buscando no promover la iniciativa SAFER como único medio para lograrlo sin el análisis propio y detallado de otras acciones que viven dentro de la Estrategia Global y que puedan ser desarrolladas por los países miembros. Recordemos que la iniciativa SAFER no ha sido ratificada por los estados miembros por lo que no debería estar por encima de las demás iniciativas que se desarrollen o existan.

En México, ante la grave crisis sanitaria que se vive por el COVID-19, se han establecido diversas medidas prohibicionistas a la comercialización y distribución de bebidas alcohólicas. Estas acciones han logrado que una mayor cantidad de bebidas apócrifas estén siendo consumidas principalmente en zonas donde la población es más vulnerable. Esto ha causado hasta el momento un gran número de muertes a lo largo del país. Lamentablemente, esto ha sido una fuerte manera de corroborar que el camino de la prohibición siempre llevará al aumento del consumo de productos ilegales que ponen en riesgo la salud de los consumidores. Por lo anterior, solicitamos que se revise el Plan de Acción para que no se centralicen las recomendaciones en el desarrollo de medidas prohibitivas al consumo, pero que si se establezcan mejores mecanismos para reducir la ilegalidad en el sector de bebidas con alcohol.

Se debe combatir el consumo nocivo de alcohol, pero no es lo que el Plan de Acción propuesto atiende. El Plan es poco claro en diferenciar claramente entre acciones que atiendan el consumo nocivo y el consumo *per se* por lo que los esfuerzos del Plan deben avocarse a atender el consumo nocivo; considerando que no hay evidencia que el consumo moderado de alcohol representa un riesgo para la salud de los consumidores.

Los avances en la reducción del consumo nocivo del alcohol en México se han logrado en colaboración entre organismos de gobierno y otras organizaciones de la industria desarrollando programas de impacto sin que exista un conflicto de interés. Esto muestra que las colaboraciones entre gobierno e iniciativa privada pueden y deben darse en el marco del respeto de la competencia de cada una de ellas. Esto, sumado a que los recursos económicos destinados por los gobiernos generalmente son limitados y el financiamiento de la industria es un elemento valioso para el desarrollo de programas más efectivos contra el combate al consumo nocivo de alcohol, por lo que pedimos que la industria y sus diferentes organismos sean integrados permanentemente en las discusiones globales en esta materia.

Agradecemos la atención que le preste a los comentarios emitidos por esta asociación y sean considerados en el desarrollo de un Plan de Acción para la implementación de la Estrategia Mundial para reducir consumo nocivo de Alcohol efectivo e inclusivo.

Lic. Alan Loredo Trueba.
Presidente de la Rama 27 “Bebidas Alcohólicas”

Cámara Nacional de la Industria Tequilera

Country/Location: Mexico

URL: www.tequileros.org

Submission

1. Ampliación de las opciones de políticas: Tomar en cuenta las circunstancias nacionales a fin de aplicar las políticas públicas que más convengan, evitando enfocarlo únicamente a la iniciativa SAFER.
2. Precisión del enfoque: Combatir uso nocivo del alcohol, en lugar del consumo per cápita. Los factores económicos, demográficos, culturales, entre otros, de cada país, podrían influir en la medición, por ello, los indicadores deben enfocarse al uso nocivo, en lugar de consumo per se.
3. Suma de esfuerzos entre diversos actores: Operadores económicos. La colaboración de diversos actores, incluyendo a los operadores económicos, tendrá resultados más favorables. Específicamente, el sector tequilero reitera su interés y compromiso en sumar esfuerzos para la reducción del uso nocivo del alcohol.

Attachment(s): 1

00210_28_comentarios-de-la-cnit-consulta-de-la-oms.pdf

Guadalajara, Jal., A 04 de diciembre de 2020

Asunto: Comentarios en la Consulta web de la OMS sobre el Proyecto de Plan de Acción para implementar la Estrategia Mundial para reducir el uso nocivo del alcohol

La Cámara Nacional de la Industria Tequilera, institución líder responsable de representar los intereses de los productores de Tequila, con el objetivo principal de proteger la Denominación de Origen Tequila, y generar las condiciones que permitan la competitividad del sector a nivel global, agradece la oportunidad de proporcionar comentarios sobre el proyecto del Plan de Acción para implementar la Estrategia Mundial para reducir el uso nocivo del alcohol.

Dado que una de las cuatro líneas estratégicas de la Cámara Tequilera está enfocada en la Responsabilidad Social y sustentabilidad de la Industria, nuestra institución apoya iniciativas e implementa estrategias para luchar contra el uso nocivo del alcohol.

En ese sentido, nos gustaría mencionar que nuestra industria está plenamente comprometida con este importante asunto y nos complace compartir los siguientes puntos solicitando respetuosamente sean tomados en cuenta:

1. Ampliación de las opciones de políticas.

Considerando lo que establece la Estrategia Mundial, consideramos conveniente que, se tomen en cuenta las circunstancias nacionales a fin de aplicar las políticas públicas que más convengan, evitando enfocarlo únicamente a la iniciativa SAFER.

Para el caso de nuestro país, cabe señalar que la efectividad y pertinencia de este tipo de acciones de política pública enfocadas a los “Best buys”, se ven en gran medida afectadas por la circunstancia que se presenta en México caracterizada por la fuerte presencia del comercio informal de bebidas alcohólicas, que, de acuerdo a las estimaciones arrojadas en estudios realizados en los últimos años, éste representa cerca del 40% del total del alcohol que se consume en nuestro país.

En ese sentido, mencionar que tanto la restricción de las bebidas alcohólicas, como el incremento de sus impuestos, tendrían una repercusión económica y social, ya que esta acción podría contribuir a la decisión de los consumidores de migrar al mercado informal, afectando de manera significativa la salud de la población y abriendo la posibilidad de la existencia de otros riesgos sanitarios. Esto, también redundaría en la no recaudación de impuestos, afectando los ingresos del gobierno, impactando el presupuesto destinado a servicios y programas de salud.

2. Precisión del enfoque: Combatir uso nocivo del alcohol, en lugar del consumo per cápita.

Sugerimos revisar el indicador de consumo de alcohol per cápita, tomando en cuenta desde un principio que el objetivo de la estrategia es la reducción del uso nocivo y no del consumo per se del alcohol. Nuevamente los factores económicos, demográficos, culturales, entre otros, podrían influir en la medición, abriendo la posibilidad de que los resultados no muestren el alcance real de la problemática.

El hecho de que una persona consuma determinada cantidad de alcohol al año, no asegura que el uso de la bebida sea adecuado en todo momento, es decir, si los esfuerzos se enfocan a medir el consumo per cápita en lugar de medir el uso nocivo, no se considerarían diversos e importantes campos de estudio, como lo son el consumo en

mujeres embarazadas o el consumo explosivo, que implica la ingesta de grandes cantidades de alcohol en una sola ocasión.

Por otra parte, mencionar que los programas sociales, hablando específicamente de nuestro país, tienen un impacto significativo, al ser estos una herramienta de prevención del uso nocivo del alcohol, creando conciencia sobre la moderación y responsabilidad ante su consumo. Dichos programas son enfocados tanto consumidores actuales, como a los potenciales en un futuro y sus círculos sociales, así como al personal de servicio en puntos de consumo y venta.

3. Suma de esfuerzos entre diversos actores: Operadores económicos.

En la industria tequilera creemos firmemente que, así como lo marca la Estrategia Mundial, la colaboración de diversos actores, en todos los niveles, incluyendo a los operadores económicos, tendrá resultados más favorables que si sólo se toma en cuenta la postura de algunos de ellos.

Como bien mencionábamos anteriormente, en nuestro sector contamos con grupos de trabajo enfocados a la reducción del uso nocivo del alcohol, a través de diversos programas, talleres y actividades dirigidos a la población, abarcando diversos públicos, esto además del cumplimiento normativo tanto a nivel nacional como internacional, como es la inclusión de leyendas precautorias y símbolos, entre otros, desincentivando así el consumo de alcohol en menores de edad, mujeres embarazadas, etc.

Es importante tomar en cuenta los conocimientos y experiencia de todos los actores; la industria de bebidas alcohólicas reitera constantemente su interés y compromiso en sumar esfuerzos para combatir el uso nocivo del alcohol. Cabe mencionar que, muchas de las empresas cuentan actualmente con un área enfocada al estudio y apoyo en actividades relacionadas al combate del uso nocivo.

Asimismo, los operadores económicos, trabajan día a día en proporcionar a los consumidores y público en general, información verídica de sus productos, a través de las propias etiquetas, así como de su publicidad, redes sociales y demás canales de comunicación. Al tener los consumidores acceso a la información de los productos, les permite contar con más herramientas que les apoye en su decisión de compra y de consumo, los empodera guiándolos a adquirir productos formales y conocer la mejor manera de degustar sin llegar al exceso.

Agradecemos de antemano su consideración y esperamos seguir contando su apoyo, buscando siempre un beneficio común.

Atentamente,



Alfonso Mojica Navarro
Director General

Tequila, regalo de México para el mundo

Canadian Centre on Substance use and Addiction

Country/Location: Canada

URL: www.ccsa.ca

Submission

The Canadian experience with the regulation of alcohol since the Global Strategy to Reduce the Harmful Use of Alcohol was endorsed in 2010 has been one of continued liberalization. Since the onset of the COVID-19 pandemic, additional policy changes have been made making alcohol more available with fewer government controls on sales and consumption. Canadians deserve to have evidence-based regulations and laws to reduce alcohol's risks and therefore, an action plan to boost the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol is clearly a good idea. However, for alcohol control measures to be given more attention by Canadian governments, an international treaty modelled on the Framework Convention on Tobacco Control is needed. We recommend that, along with the adoption of the action plan, the WHO take the first steps toward a binding alcohol control agreement that will set off a chain reaction to develop and implement national alcohol policies in the interest of public health and security.

Attachment(s): 1

00398_49_who-consultation-on-the-action-plan-2020-id-40044.pdf



Comments on the WHO Working Document: Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

The Canadian Centre on Substance Use and Addiction (CCSA) prides itself on being an independent, neutral, non-partisan and trusted third-party expert on substance use and addiction. Our work is always firmly rooted in science and sound methodology, and driven by compassion. CCSA also recognizes the power of the traditional knowledge held by the First Peoples. These qualities make CCSA a trusted adviser in Canada for all levels of government.

For more than three decades, CCSA has continued to build the trust that has enabled us to work with governments across the political spectrum to advance initiatives that reduce harms, improve wellness and increase community safety across Canada. In doing so, CCSA brings together governments, organizations and people with disparate voices to help Canadians lead healthier, more productive lives.

As much as CCSA is a credible voice and an established leader in the field of substance use and addiction, as a national organization it has an equal responsibility to recognize and encourage the innovative work being done throughout Canada. It takes seriously its role of collaborating with other Canadian scientists and service providers to help advance their work and shine a light on the progress being made in every corner of the country.

It is from this position that CCSA offers the following comments on the World Health Organization's *Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol*.

From the Global Alcohol Strategy to the Action Plan

The basic premise of the WHO working document and rationale for the action plan is that between 2010 and 2018 no tangible progress has been made in reducing global alcohol consumption. This premise holds true in Canada, where the average amount of pure alcohol consumed by people aged 15 and over has stayed relatively stable at about eight litres annually. A further concern is the proportion of Canadians whose consumption is classified as heavy drinking, defined as consuming 60 grams or more of pure alcohol on at least one occasion in the past 30 days, which rose from 17.8% in 2010 to 21.2% in 2016 (World Health Organization, 2019). In 2014, the overall cost of alcohol use in Canada was \$14.6 billion per year, which means the country was running an alcohol deficit of about \$3.7 billion, when accounting considers government revenue compared with societal costs (Sherk, 2020). These numbers indicate that Canada has not been able to take advantage of the WHO Global Alcohol Strategy.

In the Canadian context, an action plan to boost the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol is clearly a good idea. What is unclear, however, is how the plan will elicit actions that the Global Alcohol Strategy itself could not.



The Canadian experience with the regulation of alcohol since the Global Strategy to Reduce the Harmful Use of Alcohol was endorsed in 2010 has been one of continued liberalization. Canada has witnessed multiple legal and regulatory amendments that make alcohol increasingly visible, accessible and affordable. These amendments include allowing more stores to sell alcoholic beverages, decreasing the minimum price of beer, increasing the weekly legal limit on the hours of alcohol sales, allowing alcohol consumption in a greater number of public areas, legalizing tailgate parties, easing the process for obtaining a permit to sell alcohol and other measures.

Since the onset of the COVID-19 pandemic, additional policy changes have been made making alcohol more available with fewer government controls on sales and consumption. While many of these policy measures were initially intended to be time-limited, there is increasing momentum across the country for maintaining these measures on a permanent basis (Platt, 2020). Ontario, the largest Canadian province, has announced that it is making permanent the temporary pandemic measure allowing restaurants and bars to sell takeout beer, wine and spirits (Benzie, 2020).

The trend toward liberalization of alcohol regulations continues despite sustained efforts from organizations like CCSA to collect and disseminate evidence about alcohol use and its associated health risks, and motivate and engage stakeholders in the implementation of the global strategy.

To slow the growth of global alcohol use and harms, Member States, supported by the WHO secretariat and non-state actors, need to develop and implement concrete actions. To this end, the working document is an all-encompassing plan that includes nearly one hundred clearly defined examples of actions that can be taken to implement cost-effective policies to address the harms of alcohol use.

Nonetheless, the plan is not a legally binding international agreement. Just as health communication strategies can increase knowledge and awareness, but on their own have little effect on the adoption of healthy behaviours, the action plan has potential to increase knowledge about what works to reduce adverse health impacts and social harms from alcohol use, but on its own has little chance to lead to the adoption the most cost-effective options or “best buys” in alcohol control as presented by the WHO working document.

Need for a Legally Binding Instrument to Reduce the Demand for and Supply of Alcohol Products

One of the most cost-effective alcohol interventions is the enforcement of bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media, including digital media. To achieve this end, starting in 2014, Finland and then Sweden adopted laws restricting alcohol-related web content and forbidding alcohol marketing on social media. Five years later, it was revealed that the initiatives had no real impact on the ability of alcohol producers to engage with consumers and that, in fact, they became even more successful in engaging consumers on social media (Kauppila, Lindeman, Svensson, Hellman, & Katainen, 2019). The Nordic initiatives brought to light the limits, resulting from trans-boundary issues, of national legislation to curtail alcohol problems. They provided further proof that an international convention on alcohol control might be the only instrument that could effectively counter a trend toward weakening national alcohol policies and regulations.

Fourteen years ago, the scientific community pointed out that calling on governments to implement an intergovernmental code of conduct through enacting national legislation and asking industries to voluntarily comply with the code had not been a sufficient strategy to address tobacco control and neither would it be sufficient for alcohol control (American Public Health Association, 2006). The observation holds true for yesterday, today and tomorrow, especially.



Recommendation

In Canada, only the implementation of “best buys” to reduce the health impacts and social harms of alcohol use will lead to change. But within Canadian culture, where alcohol use is normalized and alcohol problems are often trivialized, it is challenging for Canada to adopt “best buys” in the short or medium term. However, Canadians deserve to have evidence-based regulations and laws to reduce alcohol’s risks. For alcohol control measures to be given more attention by Canadian governments, an international treaty modelled on the Framework Convention on Tobacco Control is needed. One of WHO’s greatest achievements, the Framework Convention on Tobacco Control counters the increase in tobacco consumption by making it a legal requirement for countries to introduce certain tobacco control strategies. It is time for a similar Framework Convention on Alcohol Control to be adopted.

Therefore, we recommend that, along with the adoption of the action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol, the WHO take the first steps toward a binding alcohol control agreement. Only a binding alcohol control agreement has the potential to set off a chain reaction to develop and implement national alcohol policies in the interest of public health and security.

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Canadian Centre
on Substance Use
and Addiction

CCSA was created by Parliament to provide national leadership to address substance use in Canada. A trusted counsel, we provide national guidance to decision makers by harnessing the power of research, curating knowledge and bringing together diverse perspectives.

CCSA activities and products are made possible through a financial contribution from Health Canada. The views of CCSA do not necessarily represent the views of Health Canada.

CEEV, Comité Européen des Entreprises Vins

Country/Location: Belgium

URL: <https://www.ceev.eu/>

Submission

CEEV draft contribution to the WHO Web based consultation on a working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol

1. CEEV

Comité Européen des Entreprises Vins (CEEV) represents the European Union wine companies in the industry and trade (still wines, aromatised wines, sparkling wines, liqueur wines and other vine products). It brings together 23 national organisations from 12 EU Member States, plus Switzerland and Ukraine, as well as a consortium of 4 leading European wine companies. The companies represented by CEEV, mainly SMEs, produce and market most quality European wines, both with and without a geographical indication, and account for over 90% of European wine exports.

The consultation is asking submitters to provide comments and suggestions as indicated in the following sentence: “We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following general and specific comments and suggestions for consideration:”

2. COMMENTS ON THE GENERAL FRAMEWORK

Concerning the general framework as presented in the working document, we would like to highlight the following general comments:

- Positive results of GAS in the last decade. The Global Strategy to reduce the harmful use of alcohol contributed to the significant reduction of harmful drinking that has been registered in the last decade as several reports showed. The reduction concerns heavy episodic drinking (HED), underage drinking, drive drinking as well as mortality and morbidity linked to harmful use of alcohol. Among the positive achievements of the GAS it is worth to mention the involvement of the wine industry in the harmful use of alcohol reduction effort.
- The action plan should recognise the positive contribution of economic operators in reducing the harmful use of alcohol. The wine industry demonstrate a strong proactive engagement in fighting harmful use of alcohol. It is worth to mention the Wine in Moderation – art de vivre programme, launched by the wine sector and its successful achievements in contributing to the reduction of harmful use of alcohol in the last decade
- Consistency with WHO Member States Decisions. All elements of the action plan should be consistent with the Global Strategy to reduce the harmful use of alcohol and the 2018 UN Political Declaration.

3. COMMENTS ON THE ACTION AREAS

A. Implement a full menu of policy options for more efficiency

The availability within the GAS of a full menu of policy option rather than a ranking represents one of the main elements that contributed to achieve positive results within the implementation of the Global Strategy. This approach agreed by WHO Member States in the WHA and EB allows to ensure enough flexibility to take on board regional specificities and differences.

- o The identification of high impact policy options should be done at national or regional level to better adapt efficient solutions to the national or regional specificities including socio-economic and cultural. No “one size fits all” approach should be adopted.
- o The action plan should not be used to promote exclusively the SAFER initiative above all other interventions agreed by WHA in 2010 as it is suggested in Action Area 1. The SAFER initiative is a technical package produced by the WHO secretariat in 2018 without Member States input or endorsement and, consequently, cannot be presented as the only mechanism for addressing harmful use. In addition, the working document should not propose as a first global target tracking progress solely on a country’s implementation of the SAFER initiative as this process will fail to recognise progress made in implementing other policies identified in the Global Strategy.
- o The action plan should take in consideration that in several countries there is a lack of evidence on the effectiveness of some measures included in the SAFER notably the best buys.
- o Restrictions in availability can lead to the growth of the unrecorded/illicit market with all its negative impact on health and criminality rise.

B. Maintain focus on the harmful use of alcohol and not on consumption per se.

Scientific evidence shows that drinking alcoholic beverages more than what’s recommended in the moderation guidelines is associated with serious health consequences. Alcohol abuse (drinking in excess on a regular basis or binge drinking) are the wrong drinking behaviours for which the Global strategy has been adopted. The vast majority of individuals choosing to consume alcoholic beverages do it in moderation. The consumption per capita cannot be considered an indicator to measure harmful use of alcohol.

- o The Action plan should thus not make recommendations aimed at reducing consumption per se but stick to the objectives of the Global strategy that consist in reducing the harmful use of alcohol.
- o More emphasis should be put on harm indicators related to HED, Underage drinking, mortality and morbidity linked to harmful use of alcohol.
- o Targets of action area 1 should focus on harmful use of alcohol indicators instead of alcohol consumption per capita.
- o Due recognition should be given to the positive trends in harmful use that have taken place since the Global Strategy was agreed. The action plan should focus on building upon and accelerating those trends and addressing gaps where such progress has not been attained.
- o Robust scientific evidence shows the importance of drinking patterns. Drinking in moderation on a regular basis during the week within meals and a balanced diet is not linked to any health risk increase while the consumption of the same amount of alcohol during the weekend without meals is linked to

negative effects which makes the national consumption pro capita indicator useless to understand harmful use of alcohol national trends.

- o Moderate wine drinkers within a balanced diet such as the Mediterranean one, have a lower disease or mortality risk than those who abstain or drink heavily. Scientific evidence should be taken in consideration.

C. Enhance the positive contribution of economic operators – whole-of-society approach

Economic operators can make a positive contribution to reducing the harmful use of alcohol, including through the effective use of their unique expertise, insights, and resources, and through support for co-regulatory systems.

The 2018 UNPD underscored “the importance of pursuing whole-of-government and whole-of-society approaches” in responding to the challenge of non-communicable diseases. In parallel, the Global Strategy states that “Policies to reduce the harmful use of alcohol must reach beyond the health sector, and appropriately engage such sectors as development, transport, justice, social welfare, fiscal policy, trade, agriculture, consumer policy, education and employment, as well as civil society and economic operators.”

The working document marginalises the role of economic operators, presents them as a barrier to progress, and gives no recognition to the positive contribution of economic operators.

- o To be consistent with the Global Strategy and the 2018 UNPD, the working document should acknowledge this and not portray economic operators as a barrier to progress. The action plan must fully incorporate economic operators within a whole-of-society response to the harmful use of alcohol, and recognise that a whole-of-society approach should be taken at all levels – multilateral, regional and national.

- o The working document suggests that all other stakeholders can interact as part of a whole-of-society approach, but economic operators should have only limited dialogue through WHO, not with MS or other actors.

- o Economic operator should be fully involved in dialogue and partnership to address harmful use of alcohol within action 3 of action area 3 on the basis of the professional expertise and knowledge of the business.

- o The working document claims the existence of a conflict of interests arguing, without citing evidence, that “a significant proportion of alcoholic beverages are consumed in heavy drinking occasions and by people affected by AUD, illustrating the inherent contradiction between the interests of alcohol producers and public health”. In addition, there are several references in the working document to “interference by commercial interests”.

- o By questioning economic operator’s commitment to public health, the working document directly contradicts the UNPD, which clearly stated that economic operators have a role to play in producing positive health outcomes through a whole-of-society approach.

- o Concerning Action 3 of action area 1 it is worth to mention that not only industry is strongly committed to contribute to the elimination of marketing and sales of alcoholic beverages to minors and

targeted commercial activities towards other high-risk groups. But moreover, industry is strongly committed to promote moderation and responsibility related to drinking among those who choose to consume alcoholic beverages. In this field, the working document should recommend the reinforcement and implementation of existing sectoral responsible standards in the field of communication, like the Wine Communication Standard from www.wineinmoderation.com that have demonstrated their effectiveness.

D. The importance of a healthy lifestyle

The importance of training, information, education actions and awareness campaigns aiming at promoting moderation and responsibility towards drinking among consumers and professionals should be enhanced in the draft action plan for a more effective implementation of the GAS.

- o The following topics should be addressed in the above-mentioned actions
 - the drinking patterns (drink within meals, alternate with water, drink in moderation)
 - The drinking guidelines
 - Who should not drink
 - The risk linked to excessive alcohol consumption
- o Those actions could take place among Action 3 of action area 2.

E. Knowledge production and science

Policy decisions should be science and fact based. Many studies have been released on alcoholic beverages relation to health and more work has to be done. Science evidence and findings have to be communicated in an accurate and truthful manner. While it is true that scientific evidence needs to be digested when communicated to public opinion to obtain a simple communication this can not lead to simplistic communication creating confusion among citizens.

F. Labelling of alcoholic beverages.

The working document calls for working on the development of international standards for labelling of alcoholic beverages to inform consumers about the content of the products and the health risks associated with their consumption.

- o The draft action plan should remain consistent with the Global Strategy which does not identify the development of international labelling standards of alcoholic beverages as an area of action of the Global Strategy.
- o The document should acknowledge the works of an international standard for wine labelling already develop by an intergovernmental organisation – the International Organisation of Vine and Wine.
- o Concerning the action 3 of Action Area 2 it is worth to mention that the European wine industry has successfully called for a compulsory legislation to provide additional information to the consumer, including the list of ingredients and the nutrition declaration, and is developing new tools to achieve this objective.

G. Taxation.

The taxation topic is mainly under Member States competence and closely linked to national specificities. Taxation should take into account the specificities of the production and structure of the wine sector. Moreover, the implementation of increases in alcohol taxation as suggested by enhancing the implementation of SAFER initiative can be linked to the increase of illicit alcohol trade with negative consequences on consumer health. The working document not only makes several references to increasing taxes on alcohol beverages (an element of the SAFER initiative), but also calls for earmarked taxation on alcohol beverages to fund prevention and treatment of alcohol use disorders.

- o The working document proposes a target for increasing the number of countries that have earmarked tax revenue for reducing the harmful use of alcohol. This is despite previous WHO documents stating that there is an “active debate over the potential advantages and disadvantages of earmarking revenues and contributions”, citing inefficiency and distortions in the economy as disadvantages of this approach.

- o Furthermore, the working document proposes that consideration be given to an intergovernmental commitment to a global tax that would be governed internationally and used to support treatment of alcohol use disorders. How such a tax would be governed, or what role WHO would play in this is not set out. No mention is made of the absence of WHO and WHA competence on matters related to tax.

- o It needs to be recalled that the Global Strategy suggests Member States give regard to “regulating sales of informally produced alcohol and bringing it into the taxation system” as part of an efficient taxation system.

H. Framework Convention on Alcohol.

The working document raise the call for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control, and discussions about the feasibility and necessity of such a legally binding international instrument.

- o The adoption of a framework convention on alcohol similar to the one adopted for tobacco was already proposed in previous WHO secretariat documents and rejected by Members States.

I. International trade

International trade is a Member State competence, and at the multilateral level, the competence of the World Trade Organisation. The action plan should not make any proposals to expand the role for the WHO secretariat related to international trade.

J. Digital marketing and commerce

The working document states that the dialogue with economic operators should also aim for implementation of comprehensive restrictions or bans on traditional, online or digital marketing (including sponsorship), as well as on sales, e-commerce, delivery, product formulation and labelling, and data on production and sales.

- o The focus should be put on creating a controlled environment to fight alcohol abuse instead of trying to ban alcoholic products from the digital environment and fostering economic operators

commitments to actively collaborate to ensure that digital marketing is effectively managed and consistent with efforts to reduce harmful drinking.

Attachment(s): 1

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CEEV draft contribution

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appropriately engage such sectors as development, transport, justice, social welfare, fiscal policy, trade, agriculture, consumer policy, education and employment, as well as civil society and economic operators.” The working document marginalises the role of economic operators, presents them as a barrier to progress, and gives no recognition to the positive contribution of economic operators.

- To be consistent with the Global Strategy and the 2018 UNPD, the working document should acknowledge this and not portray economic operators as a barrier to progress. The action plan must fully incorporate economic operators within a whole-of-society response to the harmful use of alcohol, and recognise that a whole-of-society approach should be taken at all levels – multilateral, regional and national.
- The working document suggests that all other stakeholders can interact as part of a whole-of-society approach, but economic operators should have only limited dialogue through WHO, not with MS or other actors.
- Economic operator should be fully involved in dialogue and partnership to address harmful use of alcohol within action 3 of action area 3 on the basis of the professional expertise and knowledge of the business.
- The working document claims the existence of a conflict of interests arguing, without citing evidence, that “a significant proportion of alcoholic beverages are consumed in heavy drinking occasions and by people affected by AUD, illustrating the inherent contradiction between the interests of alcohol producers and public health”. In addition, there are several references in the working document to “interference by commercial interests”.
- By questioning economic operator’s commitment to public health, the working document directly contradicts the UNPD, which clearly stated that economic operators have a role to play in producing positive health outcomes through a whole-of-society approach.
- Concerning Action 3 of action area 1 it is worth to mention that not only industry is strongly committed to contribute to the elimination of marketing and sales of alcoholic beverages to minors and targeted commercial activities towards other high-risk groups. But moreover, industry is strongly committed to promote moderation and responsibility related to drinking among those who choose to consume alcoholic beverages. In this field, the working document should recommend the reinforcement and implementation of existing sectoral responsible standards in the field of communication, like the Wine Communication Standard from www.wineinmoderation.com that have demonstrated their effectiveness.

D. The importance of a healthy lifestyle

The importance of training, information, education actions and awareness campaigns aiming at promoting moderation and responsibility towards drinking among consumers and professionals should be enhanced in the draft action plan for a more effective implementation of the GAS.

- The following topics should be addressed in the above-mentioned actions
 - the drinking patterns (drink within meals, alternate with water, drink in moderation)
 - The drinking guidelines
 - Who should not drink
 - The risk linked to excessive alcohol consumption
- Those actions could take place among Action 3 of action area 2.

E. Knowledge production and science

Policy decisions should be science and fact based. Many studies have been released on alcoholic beverages relation to health and more work has to be done. Science evidence and findings have to be communicated in an accurate and truthful manner. While it is true that scientific evidence needs to be digested when communicated

to public opinion to obtain a simple communication this can not lead to simplistic communication creating confusion among citizens.

F. Labelling of alcoholic beverages.

The working document calls for working on the development of international standards for labelling of alcoholic beverages to inform consumers about the content of the products and the health risks associated with their consumption.

- The draft action plan should remain consistent with the Global Strategy which does not identify the development of international labelling standards of alcoholic beverages as an area of action of the Global Strategy.
- The document should acknowledge the works of an international standard for wine labelling already develop by an intergovernmental organisation – the International Organisation of Vine and Wine.
- Concerning the action 3 of Action Area 2 it is worth to mention that the European wine industry has successfully called for a compulsory legislation to provide additional information to the consumer, including the list of ingredients and the nutrition declaration, and is developing new tools to achieve this objective.

G. Taxation.

The taxation topic is mainly under Member States competence and closely linked to national specificities. Taxation should take into account the specificities of the production and structure of the wine sector. Moreover, the implementation of increases in alcohol taxation as suggested by enhancing the implementation of SAFER initiative can be linked to the increase of illicit alcohol trade with negative consequences on consumer health. The working document not only makes several references to increasing taxes on alcohol beverages (an element of the SAFER initiative), but also calls for earmarked taxation on alcohol beverages to fund prevention and treatment of alcohol use disorders.

- The working document proposes a target for increasing the number of countries that have earmarked tax revenue for reducing the harmful use of alcohol. This is despite previous WHO documents stating that there is an “active debate over the potential advantages and disadvantages of earmarking revenues and contributions”, citing inefficiency and distortions in the economy as disadvantages of this approach.
- Furthermore, the working document proposes that consideration be given to an intergovernmental commitment to a global tax that would be governed internationally and used to support treatment of alcohol use disorders. How such a tax would be governed, or what role WHO would play in this is not set out. No mention is made of the absence of WHO and WHA competence on matters related to tax.
- It needs to be recalled that the Global Strategy suggests Member States give regard to “regulating sales of informally produced alcohol and bringing it into the taxation system” as part of an efficient taxation system.

H. Framework Convention on Alcohol.

The working document raise the call for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control, and discussions about the feasibility and necessity of such a legally binding international instrument.

- The adoption of a framework convention on alcohol similar to the one adopted for tobacco was already proposed in previous WHO secretariat documents and rejected by Members States.

I. International trade

International trade is a Member State competence, and at the multilateral level, the competence of the World

Trade Organisation. The action plan should not make any proposals to expand the role for the WHO secretariat related to international trade.

J. Digital marketing and commerce

The working document states that the dialogue with economic operators should also aim for implementation of comprehensive restrictions or bans on traditional, online or digital marketing (including sponsorship), as well as on sales, e-commerce, delivery, product formulation and labelling, and data on production and sales.

- The focus should be put on creating a controlled environment to fight alcohol abuse instead of trying to ban alcoholic products from the digital environment and fostering economic operators commitments to actively collaborate to ensure that digital marketing is effectively managed and consistent with efforts to reduce harmful drinking.

Center for Indonesian Policy Studies

Country/Location: Indonesia

URL: <https://www.cips-indonesia.org>

Submission

In the working document, the WHO shifts its Global Strategy focus away from “reducing harmful alcohol” to “restricting alcohol”. The document recommends prohibitionist policy options but fails to fully consider the danger of the illicit alcohol market that may arise out of those policies. The combination of limited availability and reduced affordability through increased excise tariffs on recorded alcohol, when coupled with demand for alcoholic beverages, would present large potential for black market of illicit alcohol which carries increased health risks. The risk of shifting to illicit alcohol is made even greater given the possible digitalization and online distribution of alcohol. In sum, the WHO should pay more attention to the risk of illicit alcohol consumption. The global targets should focus on reducing harmful use of alcohol, especially illicit alcohol, by regulating instead of restricting all alcohol consumption altogether.

Attachment(s): 1

00204_24_cips-response-on-who-global-alcohol-strategy-consultation-2020.pdf

Summary

In the working document, the WHO shifts its Global Strategy focus away from “reducing harmful alcohol” to “restricting alcohol”. The document recommends prohibitionist policy options but fails to fully consider the danger of the illicit alcohol market that may arise out of those policies. The combination of limited availability and reduced affordability through increased excise tariffs on recorded alcohol, when coupled with demand for alcoholic beverages, would present large potential for black market of illicit alcohol which carries increased health risks. The risk of shifting to illicit alcohol is made even greater given the possible digitalization and online distribution of alcohol. In sum, the WHO should pay more attention to the risk of illicit alcohol consumption. The global targets should focus on reducing harmful use of alcohol, especially illicit alcohol, by regulating instead of restricting all alcohol consumption altogether.

Increased black market of alcohol

WHO’s working document (2020) and its SAFER-initiative recommend strengthening restrictions to alcohol availability, without differentiating recorded versus unrecorded alcohol. This approach can have an unintended consequence of increasing illicit or unrecorded alcohol, which carries higher risk of excessive and harmful use and negative health outcomes. When safe access to recorded alcohol is limited, consumers would be encouraged to shift to illicit and unrecorded alcohol. For example, a study in Indonesia found that there was a significant increase of confiscated unrecorded alcohol after Indonesia introduced a national policy that limits alcohol distribution only to select hotels, bars, and restaurants geared towards tourism, duty free shops, and very few specific places (Uddarojat, 2016). Until now, unrecorded alcohol dominates the Indonesian market with total consumption of 0.5 liter of unrecorded pure alcohol, compared to 0.3 liter of recorded pure alcohol (WHO, 2018).

The prevalence of unrecorded alcohol may carry higher public health risks and increased mortality (Probst et al., 2019; Lachenmeier, 2012). The increased risks come from potential toxicity of unrecorded alcohol due to other compounds (such as methanol, propanol, butanol,

polyhexamethylene guanidine) (Lachenmeier, Gmel, & Rehm, 2013) as well as higher rates of chronic and irregular heavy drinking (Rehm et al., 2014).

The concern on illicit alcohol is properly acknowledged in the 2010 Global Strategy (WHO, 2010), but is left unaddressed in the working document. The WHO should not ignore the risk and likelihood of black market.

Unintended consequence of taxation

While several studies have concluded that taxation is an effective strategy to reduce alcohol consumption (Babor, et al., 2010; Chisholm, Rehm, Van Ommeren, & Monteiro, 2004) there is also a concern that increased taxation will lead to an increase in unrecorded alcohol consumptions (Probst et al., 2019). According to Skehan, Sanchez, & Hastings (2016) unrecorded alcohol trade flourishes in countries with reduced disposable income or with pricing policies that limit the affordability of regulated alcohol. This situation leaves lower income consumers particularly vulnerable as they will be unable to purchase recorded alcohol and will prefer to purchase unrecorded alcohol due to the affordability of the products (Pribadi, 2017).

Not only will excise tax on alcohol disadvantage lower income population, it will also reduce government's revenue. In Indonesia, the high consumption of illicit alcohol is found to reduce government revenue from excise. A recent study from Euromonitor (2020) shows that the Indonesian government lost up to IDR 1,037.5 billion in 2018 alone due to the black market, a 17.56% increase from IDR 882.5 billion the previous year.

The call to 'Raise prices on alcohol through excise taxes and other pricing policies' should be reconsidered. Tax policies should be carefully calculated based on the externalities associated with harmful consumption but should not be excessive as it risks increasing illicit alcohol instead.

Online distribution of alcohol

Since the 2010 Global Strategy, a major change in the alcohol consumption pattern has been the emerging online alcohol sales. The working document acknowledges this trend and the challenge associated with 'greater opportunity for marketing and selling alcohol through

online platforms' (p. 5). However, the working document did not acknowledge the increased risk of illicit alcohol sold through online platforms, especially if governments of its Member States were to limit access and raise prices to legal alcohol. With reduced options, consumers, mostly low-income population, are likely to procure illicit alcohol through online channels, undermining the government's ability to monitor and prevent excessive and harmful use of alcohol.

The coronavirus pandemic appears to be increasing online sales of alcoholic beverages in some countries. A study published by Rabobank in April 2020 (Nesin, 2020) found that online alcohol sales in the US were booming. Due to the lockdown measures during the Covid-19 pandemic, off-premise sales increased from 40% to 60% year-on-year during the 3rd week of March 2020. Similar trends were seen in the United Kingdom (Carruthers, 2020) and Australia (Waters, 2020). This resonates with The Economist Intelligence Unit Report (Yang, 2020) that observed the skyrocketing volume of online ordering for regulated commodities such as tobacco and alcohol, adding an additional burden on law enforcement for its illicit market and customs organizations.

Online shopping trend is likely to continue well after the pandemic. This will increase the number of cross-border transactions which will create more cover for illicit trade if not equipped with sound regulations.

Considering the abovementioned concerns over the current version of the working document, we are recommending the WHO to reconsider the policy options on restricting licit alcohol advertising and availability. In Indonesia, the problem of restrictive policies that curbs availability and affordability of licit alcoholic beverages have resulted in increased number of victims due to counterfeit alcohol, mostly coming from low-income groups (Respatiadi & Tandra, 2018; Uddarojat, 2016). The ineffective and counterproductive policies should not be repeated globally. Increased online sales capability also carry additional challenge of monitoring illicit alcohol market. Therefore, taxation policy and prohibition policy that limits availability and affordability to licit products also should be carefully reconsidered in order to prevent the rise of unrecorded alcohol consumption.

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Center for Law and Policy Affairs

Country/Location: Bangladesh

URL: www.clpatrust.org

Submission

Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

Center for Law and Policy Affairs- CLPA is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

CLPA (Center for Law and Policy Affairs) has the mandate to ensure people's policy for development and well-being. CLPA started in 2008 working on local and national level policy and registered as a Non-profit organization in 2016. CLPA team believes in ensuring sustainable development and work towards to support and formulate national law and policy. On the spirit, CLPA works with the community level with support from professionals and community-based organizations take learning and successes to the national level by adopting bottom to top-level approach.

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

Attachment(s): 1

00447_78_working-document-to-develop-an-action-plan-for-improving-who-gas-implementation.pdf

Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

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*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

- A. 7 Points for Action Plan Improvement
 1. Ensure bold targets and ambition
 2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
 3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
 4. Ensure greater focus on the SAFER strategies;
 5. Ensure greater focus on governance and infrastructure improvements;
 6. Improve resourcing as well as reporting and review of implementation; and
 7. Update nomenclature in line with state-of-the-art evidence.

- B. Additional point to be added to the action plan
 1. Suggestion for elements of the action plan

- C. Point of criticism and request for significant change
 1. Role of the alcohol industry, conflict of interest

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome – and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.

- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world’s children. The WHO–UNICEF–Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children’s health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document’s outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan’s operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

Where possible, actions and key indicators should be time-bound.

4. Ensuring greater focus on the SAFER strategies

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions – to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol.

We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys – that has largely fallen short of necessity – is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document.

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements – learning lessons from other health areas.

Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).

6. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.
7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings – like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals – like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO’s expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

Regarding the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called “Infrastructure”.

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential – as tobacco control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the

progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies. Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden.

For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level.

We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through "SAFER pilot countries".

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial – both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets
2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.

3. Framework for action

Operational objectives: 8

Priority areas for global action: 6

Global action: WHO

National action: Member States

4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Center for youths mental health and drug abuse prevention Nigeria

Department/Unit: *Mental health and drug abuse prevention*

Country/Location: Nigeria

URL: www.nigeracenterforyouth.org

Submission

1. That alcohol industries most especially in sub Sahara Africa should be discourage from funding mental health and drug abuse prevention research projects .

That the industries should also be discouraged from financial support to academic institutions.

That appropriate legislation should be put in place most especially in Nigeria to discouraged excessive outdoor advertisement of alcohol.

Attachment(s): 0

Cerveceros de España

Country/Location: Spain

URL: www.cerveceros.org

Submission

Desde Cerveceros de España presentamos un documento con las principales consideraciones al documento de trabajo de la OMS argumentando cada declaración con estudios y evidencia científica. Dicho informe se compone de los siguientes puntos: 1. Quienes somos 2. La cerveza 3. Pautas de consumo en España 4. Cerveza sin alcohol, caso de éxito 5. Apoyo de las instituciones al sector cervecero 6. Colaboración público-privada 7. Cumplimiento de las leyes existentes.

Por otro lado, se adjunta el documento de trabajo de la OMS con las propuestas de enmiendas al mismo por parte de Cerveceros de Europa. Muchas gracias. Un saludo.

Attachment(s): 2

00325_08_consulta-web-who-cerveceros-de-españa-11.12.20.pdf

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CONSULTA WEB

Documento de trabajo de la OMS para el desarrollo de un plan de acción para fortalecer la implementación de la Estrategia mundial para reducir el uso nocivo del alcohol

"Hemos leído el documento de trabajo para el desarrollo de un plan de acción para fortalecer la implementación de la estrategia global para reducir el uso nocivo de alcohol y tenemos los siguientes comentarios y sugerencias para su consideración: "

I. Cerveceros de España

Cerveceros de España es la entidad que representa en nuestro país desde 1922 a la práctica totalidad de la producción de cerveza en España. Esta asociación engloba actualmente a: MAHOU SAN MIGUEL, DAMM, HEINEKEN ESPAÑA, HIJOS DE RIVERA, GRUPO AGORA, COMPAÑÍA CERVECERA DE CANARIAS, ALMOGAVER, AS CERVESA, BARCELONA BEER COMPANY, BIRRA&BLUES, BIDASSOA BASQUELAND BREWERY PROJECT, CALEYA, CAPITÁN, CASASOLA, CEREX, CERVEZA 976, CERVEZAS DOCESETENTA, CERVEZAS LA VIRGEN, CERVEZAS MOND, DOUGALL'S, FERNANDEZ PONS, GARAGE BEER CO, ILDA'S TOW BEER, LA GRANJA DE GOOSE, LA ROSITA, LA RUA BREWERY, LA SAGRA, MALTMAN BREWING, MAD BREWING, MONTSENY, MORLACO BEER, NAPARBIER, PENINSULA, ROCKERBEER, SCONE CRAFT BEER, TYRIS, VILLA DE MADRID y ZETA, así como AECAI (Asociación Española de Cerveceros Artesanos e Independientes).

El valor de compra en el mercado de la cerveza en España superó en 2019 los 17.800 millones de euros y generó más de 399.000 puestos de trabajo directos e indirectos, el 90% en hostelería y restauración. La actividad de las empresas cerveceras venía aportando anualmente 7.000 millones de euros a la economía y, vía impuestos, superaba los 3.600 millones de euros.

II. La cerveza

Bebida de baja graduación alcohólica

La cerveza es una **bebida fermentada de baja graduación alcohólica** (4-5% alcohol las más consumidas) elaborada con ingredientes naturales (agua, cebada y lúpulo). Como ocurre con el resto de bebidas fermentadas, como el vino o la sidra, su contenido alcohólico proviene solo de la fermentación natural de sus materias primas, por lo que mantiene muchos micronutrientes. De hecho, la cerveza y el vino, son las únicas bebidas con contenido alcohólico cuya **definición legal en España** reconoce que son **alimentos**.

La cerveza puede formar parte de un estilo de vida saludable como parte de la dieta mediterránea. Las bebidas fermentadas están incluidas en la **Pirámide de la Mediterranean Diet Foundation**¹ y en la Pirámide de la Alimentación Saludable de la SENC junto al vino siempre que su consumo sea ocasional y moderado por parte de adultos sanos.

¹ Public Health Nutr. 2011 Dec;14(12A):2274-84. doi: 10.1017/S1368980011002515. Review

Bebidas fermentadas

La comunidad científica reconoce que no todas las bebidas con contenido alcohólico son iguales. Incluso su organización abogó por un trato diferenciado para las de baja graduación, y promueve que, para reducir el consumo abusivo de alcohol, se prime el de bebidas de baja graduación².

Las bebidas fermentadas son aquellas naturales, de carácter agrícola, uso alimentario y elaboradas exclusivamente a partir de la fermentación de la uva, los cereales, los frutos carnosos o bayas.

III. Pautas de consumo de cerveza

El patrón de consumo de cerveza en España es **responsable, social y moderado**, propio de la cultura mediterránea. La cerveza se consume en un entorno social y acompañada de algo de comer (**hasta un 84% de los españoles la consume acompañada de comida**)³.

El consumo *per cápita* español ha estado históricamente por debajo del promedio de la Unión Europea. **En 2019, el consumo *per cápita* se situó en 52 litros**⁴.

Además, según los datos del **Informe Global sobre Alcohol y Salud 2018 de la OMS**, la media de **consumo de alcohol *per cápita*** en bebedores mayores de 15 años en España (en litros de alcohol puro) **ha bajado**, desde los 16,4 l en 2010 a los 14,6 l en 2016. Asimismo, la prevalencia de **episodios de “atracción” es ligeramente menor en España** que en el resto de Europa, tanto entre la población general (25,6 vs 26,4) como entre los bebedores habituales (37,3 vs 39,5%) –ver gráfico–.

De estos datos se extrae que el consumo de la cerveza en nuestro país se ha incrementado, a la vez que **el consumo *per cápita* de alcohol y la ingesta en modo “atracción” han disminuido, lo que confirma que nuestras pautas de consumo son responsables y moderadas.**

Las pautas de consumo en España de las bebidas fermentadas están asociadas a la **ingesta de alimentos y al entorno familiar**. Su consumo no está focalizado en horario nocturno o fin de semana, sino que se reparte entre todos los días de la semana y en diferentes momentos del día, siendo la tarde, el aperitivo y la comida los principales.

Preferencia por el consumo de cerveza fuera del hogar

El consumo fuera del hogar en 2019 supuso **hasta el 68%**⁵ y casi el **86%** de las ocasiones en que se consume cerveza⁶, se toma en compañía de **amigos, familia, compañeros de trabajo o pareja**, y muy pocas, en soledad.

² “Public health successes and missed opportunities: Trends in alcohol consumption and attributable mortality in the WHO European Region, 1990–2014” Organización Mundial de la Salud, 2016 y “Global strategy to reduce the harmful use of alcohol”. Organización Mundial de la Salud, 2010. ² Public Health Nutr. 2011 Dec;14(12A):2274-84. doi: 10.1017/S1368980011002515. Review

² “Public health successes and missed opportunities: Trends in alcohol consumption and attributable mortality in the WHO European Region, 1990–2014” Organización Mundial de la Salud, 2016 y “Global strategy to reduce the harmful use of alcohol”. Organización Mundial de la Salud, 2010.

³ “Valor socioeconómico del binomio cerveza-tapa”. Eratema, 2011 (81%); “Consumo de bebidas con contenido alcohólico en hostelería” Análisis e Investigación, 2016 (84%); “Estudio sobre la tapa y su consumo en hostelería”. FEHR, 2016 (70%)

⁴ Informe socioeconómico del sector cervecero español 2019

⁵ Compra y consumo de Cervezas Fuera del Hogar en España” 2019. Kantar

⁶ Compra y consumo de Cervezas Fuera del Hogar en España” 2019. Kantar

V. Cerveza sin alcohol, caso de éxito

España es principal consumidor y productor de cerveza sin alcohol de la UE, con un 13% del consumo *per cápita*, algo que no solo se debe a la alta calidad y apuesta por la innovación de las cerveceras españolas, sino también a los hábitos y consideración de los españoles a esta bebida.

Los consumidores de cerveza lo son también de cerveza sin alcohol, que la eligen como una alternativa más a los otros tipos; el 48% de quienes consumen cerveza opta por esta variedad en algún momento⁷.

De estos datos se extrae que el consumo de esta bebida en España se hace de manera responsable y siempre **buscando su sabor y propiedades, y no tanto la graduación alcohólica** que, además, en el caso de esta bebida es baja, en torno a los 4,5 grados. La cerveza sin alcohol es una opción segura para aquellas personas que **no pueden (embarazo, lactancia, profesionales en el entorno laboral, cuando van a coger el coche), o no quieren consumir alcohol, pero desean disfrutar del sabor de una cerveza.**

VI. Apoyo de las Instituciones al sector cervecero

La **Comisión Europea** propuso estimular el consumo de cerveza de baja graduación alcohólica (hasta 3,5% de alcohol) aplicándole un impuesto especial con tipo reducido, con el objetivo de que los consumidores elijan bebidas de baja graduación⁸.

WHO incluso defiende que para reducir el consumo abusivo de alcohol y los prejuicios que se derivan del mismo, se deben promocionar las bebidas de baja graduación⁹. De igual manera, un reciente estudio de Salud pública y Epidemiología de *Oxford Academics* comparte esta recomendación¹⁰.

El **Comité Económico y Social Europeo** insta a los gobiernos, compañías cerveceras, operadores económicos y sociedad civil a colaborar en campañas destinadas a fomentar un consumo de cerveza responsable, que pueda ser compatible con un estilo de vida sano, así como para evitar el abuso de alcohol.

Así, el **Dictamen del Comité Económico y Social Europeo titulado “Incentivar el potencial de crecimiento del sector cervecero europeo”**, aprobado el 16 de octubre 2013, incluye las siguientes afirmaciones:

3.7. El sistema de impuestos especiales establecido a nivel nacional y de la UE debería reconocer las características únicas de la cerveza, en particular su grado alcohólico generalmente bajo, la contribución local del proceso de elaboración de cerveza y del sector de la producción de cerveza a la sociedad, a la creación de empleo y a la economía en general. Para ello, la cerveza, en tanto que bebida fermentada, debería disfrutar de unas condiciones de competencia equitativas, y, por lo tanto, el tipo mínimo (cero euros) aplicable al vino y otras bebidas

⁷ “Compra y consumo de Cervezas Fuera del Hogar en España” 2019. Kantar

⁸ Nota de Prensa de la Comisión Europea sobre la actualización de las normas relativas a los impuestos especiales sobre el alcohol, 2018.

⁹ Public Health Successes and missed opportunities: Trends in alcohol consumption and attributable mortality in the WHO Region, 1990-2014”. Organización Mundial de la Salud, 2014.

¹⁰ Distilled Spirits Overconsumption as the Most Important Factor of Excessive Adult Mortality in Europe”, Oxford Academics, 2018.

fermentadas debería incluirse también en la legislación sobre impuestos especiales de la UE para la cerveza.

3.9. Dada **la importancia del sector hostelero** en la venta de cerveza, la política fiscal puede desempeñar también un papel generador de crecimiento en los sectores cervecero y hostelero y generar **un impacto positivo sobre el empleo a nivel local**.

4.4...Además del trabajo que proporciona la cadena de abastecimiento y suministro, el potencial gastronómico y turístico debe desarrollarse más a fin de aumentar el empleo a través de las propias actividades de los cerveceros, así como de regímenes de financiación nacionales y de la UE.

6.2. Basándose en estas actividades, **los gobiernos, las empresas cerveceras, otros operadores económicos y los grupos de la sociedad civil deberían colaborar en campañas destinadas a fomentar un consumo de cerveza responsable, que pueda ser totalmente compatible con un estilo de vida adulto sano, así como para evitar el abuso del alcohol**.

6.4. ...Este compromiso debería verse reconocido en un **marco equilibrado en materia de comercialización y de comunicación comercial** por parte de los fabricantes de cerveza.

VII. Colaboración público/privada

El documento de trabajo también sostiene que existe un conflicto inherente entre los intereses de los productores de bebidas con contenido alcohólico y los de salud pública. Este supuesto conflicto se utiliza para justificar la exclusión de todos los sectores de bebidas de todos los debates sobre políticas de salud pública. Sin embargo, **no existe un conflicto de intereses inherente entre los intereses de los cerveceros y los de la salud pública, y no hay justificación** por tanto, para excluirnos del debate.

El sector cervecero es parte de la solución

El sector cervecero mantiene un firme **compromiso con la sociedad** a través de una intensa labor de información de hábitos de consumo de cerveza responsable y moderado, en el marco de nuestras pautas mediterráneas.

Cerveceros de España apuesta por **mecanismos que han demostrado su eficacia** como la autorregulación publicitaria y las estrategias educativas y divulgativas, **colaborando y promoviendo el diálogo con todos los agentes implicados que tienen sus mismos objetivos de responsabilidad: instituciones públicas y privadas, asociaciones de consumidores y de hostelería, entidades del ámbito de la seguridad vial o sociedades médicas**.

España es un claro ejemplo de que la colaboración público-privada es efectiva a la hora de reducir el uso nocivo del alcohol, como refuerzo a las acciones de responsabilidad que realizamos.

El sector desarrolla un papel activo con la puesta en marcha de **numerosas iniciativas de prevención centradas en los menores de edad, los jóvenes, las embarazadas y en seguridad vial**. Además, adapta los mensajes a cada público de forma que resulten lo más eficaces posibles:

- **Prevención del consumo de alcohol en menores**

“**Los padres tienen la palabra**” es una campaña dirigida a los padres para fomentar su implicación a la hora de educar y ayudar a sus hijos a tomar decisiones responsables frente al consumo de alcohol.

- **Responsabilidad y moderación ante el consumo de los jóvenes adultos**

La campaña “**Un dedo de espuma, dos dedos de frente**” (www.undedodeespuma.es) fue creada en el año 2000 y está dirigida a la población en general y a los jóvenes en particular para recomendar que el consumo de cerveza sea siempre responsable y moderado, dentro de las pautas mediterráneas.

- **La incompatibilidad del alcohol y la conducción**

Con “**En la carretera, cerveza SIN**”, Cerveceros de España quiere transmitir el mensaje de que alcohol y conducción son totalmente incompatibles, tanto a los conductores y sociedad en general, como a los alumnos de las autoescuelas, y propone a los consumidores de cerveza la alternativa SIN alcohol.

- **Prevención del consumo de alcohol en el embarazo y lactancia**

Para recordar la incompatibilidad de consumo de alcohol durante el embarazo, la campaña “**Un embarazo SIN**” recomienda a las mujeres embarazadas que si van a beber cerveza, opten por la variedad sin alcohol.

Proyecto realizado en colaboración con la Sociedad Española de Ginecología y Obstetricia (SEGO), que consiste en la difusión de materiales informativos específicamente creados para los obstetras y para las mujeres embarazadas o que crean estarlo, con documentación de interés sobre el consumo de bebidas con contenido alcohólico, consejos y consejos para seguir una dieta completa y equilibrada.

Actualmente en curso la campaña, en colaboración de la Asociación Española de Matronas, “**Una lactancia SIN**” con el objetivo de promover hábitos saludables de alimentación, insistir en que durante la lactancia no deben consumirse bebidas con contenido alcohólico y presentar la cerveza sin alcohol como una opción segura durante la lactancia.

- **Autorregulación publicitaria y campañas de concienciación**

El sector cervecero fue pionero dentro del sector de alimentación y bebidas en la aprobación de un **Código de Autorregulación Publicitaria** (en 1995) para asegurar que la comunicación comercial de las marcas asociadas a Cerveceros de España sea responsable, legal y honesta, **con especial protección de los menores de edad**; el texto recoge el firme compromiso asumido por el sector cervecero de que **sus comunicaciones nunca se dirigirán a menores**.

Por ello, **el etiquetado de los envases de cerveza** destinados al consumidor final, así como el packaging para la venta al público, incorporan **un gráfico** que informa de que este producto debe ser consumido por mayores de 18 años.



Así, el Código se ha ampliado con la inclusión de directrices que regulan la **comunicación publicitaria en el entorno digital**; incorpora un anexo con indicaciones específicas aplicables a las nuevas formas de comunicación digital con el objetivo principal de asegurar, más si cabe, que las comunicaciones comerciales del sector cervecero español no se dirijan a menores, y evitar, en la medida de lo posible, el acceso y exposición de los menores a estas comunicaciones.

Por otro lado, el sector cervecero español quiere **mejorar la información que pone a disposición de los consumidores** y ha incluido también en esta revisión su compromiso, voluntario y progresivo, de **ampliar la información nutricional y de ingredientes que incluye en el etiquetado de sus productos**, dando un paso más allá de lo requerido por la legislación española y europea.

Win-Win

La colaboración es fundamental para crear situaciones en las que todos ganen, como el liderazgo del sector de la cerveza europeo con su **compromiso de información al consumidor en el etiquetado y el crecimiento de la cerveza sin alcohol**.

VIII. Cumplimiento de las leyes existentes

Antes de la puesta en marcha de nuevas normas, es preciso hacer valer las existentes. No se deberían aplicar intervenciones dirigidas a toda la población de forma indiscriminada, como:

1. **Políticas de precios:** los consumidores abusivos de bebidas alcohólicas **no son sensibles al incremento de precio**. En cualquier caso, se trasladaría el consumo a bebidas de menor calidad, primando la cantidad frente a la calidad. Por consiguiente, cualquier política basada en el precio no afectará a la población objetivo, sino al resto, que consumen moderadamente.
2. **Restricciones a la publicidad**, pues se ha demostrado que no influyen en el consumo general de las bebidas ni en la prevención de los casos de abuso.

Un trabajo español dirigido por el **Prof. Juan A. Gimeno, Catedrático de Economía Aplicada y Gestión Pública y Rector de la UNED**, apunta que la publicidad tiene mucha más incidencia en la **distribución de la cuota interna** de ventas entre marcas. Las acciones de comunicación comercial intentan que el consumidor prefiera la suya y no la de la competencia a través de la notoriedad y la diferenciación de marca, no un incremento en el consumo de la categoría de producto. **La repercusión efectiva de la publicidad de cerveza en las cifras de consumo global de esta bebida es prácticamente inexistente¹¹**.

3. **Fijar limitaciones a la comunicación comercial de las cervezas españolas** incrementaría el consumo de “marcas blancas”, que no aportan valor añadido a

¹¹ “La Influencia de la Publicidad en el Consumo de Cerveza”. J. A. Gimeno, J. E. Castañeda y C. Navarro. UNED Ediciones. Madrid 2006

nuestra economía, primando la cantidad sobre la calidad cuyo principal atractivo es el precio.

4. **La mayoría del alcohol consumido**, principalmente por los jóvenes, **no se “publicita”**. Así en España apenas existe publicidad de combinados y el “calimocho” no lo ha hecho jamás.

Ineficacia de las medidas prohibitivas e indiscriminadas

Este sector comparte el objetivo de las políticas de alcohol de reducir y evitar el consumo inadecuado, sin necesidad de reducir el consumo per cápita, pues la mayoría de españoles consumen cerveza de forma responsable y moderada.

Por este motivo, el sector cervecero defiende que las políticas de reducción de daños ocasionados por el consumo de alcohol deberían basarse en **la evidencia científica, centrándose en colectivos y proyectos específicos adaptados a cada situación y etapa de la vida, tal y como el sector pretende con las campañas educativas que realiza.**



Working document

for development of an action plan to
strengthen implementation of the
Global Strategy to Reduce the Harmful
Use of Alcohol

14th November 2020

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SETTING THE SCENE

The Global Strategy to Reduce the Harmful Use of Alcohol

The Global Strategy to Reduce the Harmful Use of Alcohol was endorsed by the Sixty-third World Health Assembly in May 2010 (Resolution WHA63.13). The consensus reached on the Global Strategy and its endorsement by the Health Assembly was the outcome of close collaboration between WHO Member States and the WHO Secretariat. The process that led to the development of the Global Strategy included consultations with other stakeholders, such as nongovernmental organizations (NGOs) and economic operators. The Global Strategy and Health Assembly Resolution WHA63.13 build on several WHO global and regional strategic initiatives and represent the commitment by WHO Member States to sustained action at all levels. The strategy contains a set of principles that should guide the development and implementation of policies at all levels, setting out priority areas for global action and recommending target areas for national action. The strategy gives a strong mandate to WHO to strengthen action at national, regional and global levels. The vision behind the Global Strategy is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to the harmful use of alcohol and the ensuing social consequences. The Global Strategy was developed to promote and support local, regional and global actions to prevent and reduce the harmful use of alcohol (Box 1).

Box 1. Purpose, vision and aims of the Global Strategy to Reduce the Harmful Use of Alcohol (WHO, 2010)

Purpose: to support and complement public health policies in Member States, including national and local efforts.

Vision: improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to harmful use of alcohol and their ensuing social consequences.

Aims: to give guidance for actions at all levels; to set priority areas for global action; and to ~~recommend~~ list a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level, taking into account national circumstances, such as religious and cultural contexts, national public health priorities, as well as resources, capacities and capabilities.

Additional international guidance

Since the endorsement of the Global Strategy in 2010, Member States' commitment to reducing the harmful use of alcohol has been further strengthened by the adoption of the political declarations emanating from high-level meetings of the United Nations General Assembly on noncommunicable diseases (NCDs). This included the declaration in 2011 and subsequent adoption and implementation of the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 [which set a voluntary target of a 10% reduction in the harmful use of alcohol by 2025](#). In 2019 the World Health Assembly (in Resolution WHA72.11) extended the NCD global action plan to 2030, ensuring its alignment with the 2030 Agenda for Sustainable Development. The NCD global action plan lists the harmful use of alcohol as one of four key risk factors for major NCDs. The action plan enables Member States and other stakeholders to identify and use opportunities for synergies to tackle more than one risk factor at the same time, to strengthen coordination and coherence between measures to reduce the harmful use of alcohol and activities to prevent and control NCDs, and to set voluntary targets for reducing the harmful use of alcohol and other risk factors for NCDs.

Commented [M1]: The GSRHUA does not recommend policies but it set a list of policy options.

Furthermore, target 3.5 of the Sustainable Development Goals (SDGs) 2030 includes the objective of strengthening the prevention and treatment of substance abuse, including harmful use of alcohol. This reflects the broader impact of harmful alcohol use on health beyond NCDs – in areas such as mental health, violence, road traffic injuries and infectious diseases.

Evidence on the cost-effectiveness of alcohol policy options and interventions was updated in a revision of Appendix 3 to the NCD global action plan, and this appendix was endorsed by the Health Assembly in Resolution WHA70.11 (2017). This resulted in a new set of enabling and recommended actions to reduce the harmful use of alcohol. The most cost-effective actions, or “best buys”, include increasing taxes on alcoholic beverages, enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media, and enacting and enforcing restrictions on the physical availability of retailed alcohol. By prioritizing the most cost-effective policy measures, the Secretariat and partners launched the SAFER initiative. The primary objective of SAFER is to support Member States in reducing the harmful use of alcohol by enhancing ongoing implementation of the Global Strategy and other WHO and United Nations strategies. The SAFER initiative also aims to protect public health-oriented policy-making against interference from commercial interests, to establish strong monitoring systems to ensure accountability, and to track progress in the implementation of SAFER policy options and interventions.

Implementation of the Global Strategy since its endorsement

Since the endorsement of the Global Strategy, its implementation has been uneven across WHO regions. The number of countries with a written national alcohol policy has steadily increased and many countries have revised their existing alcohol policies. However, the presence of written national alcohol policies continues to be most common in high-income countries and least common among low-income countries, with written national alcohol policies missing from most countries in the African Region and the Region of the Americas. The disproportionate prevalence of effective alcohol control measures in higher-income countries raises questions about global health equity; it underscores the need for more resources and greater priority to be allocated to support the development and implementation of effective policies and actions in low- and middle-income countries.

[Between 2010 and 2018, tangible progress was made in reducing the harmful use of alcohol and alcohol-related harm reaching or exceeding the NCD target of a 10% reduction in the harmful use of alcohol by 2025. Age-standardized prevalence of heavy episodic drinking \(defined as 60 or more grams of pure alcohol on at least one occasion at least once per month\) decreased globally by 10.2% from 20.6% in 2010 to 18.5% in 2016 among the total population but remained high among drinkers, particularly in parts of Eastern Europe and in some sub-Saharan African countries \(more than 60% among current drinkers\). Alcohol-attributable death rates declined by 13% between 2010 and 2016 and alcohol-attributable DALYs declined by 10.6% between 2010 and 2016. However, between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita; the figures for people aged 15 years and over rose from 5.5 litres of pure alcohol in 2005 to 6.3 litres in 2010 and remained relatively stable at 6.2 litres in 2018. The highest levels of consumption per capita were observed in countries in the European Region. Although consumption per capita remained stable between 2010 and 2018 in the Region of the Americas and the African and Eastern Mediterranean regions, it decreased in the European Region – surpassing the target set in the global monitoring framework for NCDs. Consumption of alcohol per capita increased, however, in the South-East Asia and Western Pacific regions.](#)

The number of drinkers declined across all WHO regions between 2010 and 2016. More than half of the global population aged 15 years and older abstained from drinking alcohol during the previous 12 months. In 2016, alcohol was consumed by more than half of the population in three of the six WHO regions: the Americas, European and the Western Pacific regions. Some 2.3 billion people are current drinkers. [Age-standardized prevalence of heavy episodic drinking \(defined as](#)

~~60 or more grams of pure alcohol on at least one occasion at least once per month) decreased globally from 20.6% in 2010 to 18.5% in 2016 among the total population but remained high among drinkers, particularly in parts of Eastern Europe and in some sub-Saharan African countries (more than 60% among current drinkers). There had been emerging evidence of an increase in alcohol consumption in some population groups during the COVID-19 pandemic, at least in the early stages of the pandemic, but this was due to stockpiling effects and overall alcohol sales went down despite an increase in off-premise sales which did not compensate for the decrease in on-premise sales.~~

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In all WHO regions, higher alcohol consumption rates and higher prevalence rates of current drinkers are associated with the higher economic wealth of countries. However, the prevalence of heavy episodic drinking is equally distributed between higher- and lower-income countries in most regions. The two exceptions to this are the African Region (where rates of heavy episodic drinking are higher in lower-income countries than in higher-income countries) and the European Region (where, conversely, heavy episodic drinking is more frequent in high-income countries).

Despite ~~some-tangible~~ improvements in the number of age-standardized alcohol-attributable deaths and disability-adjusted life years (DALYs) in all regions except South-East Asia, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, the harmful use of alcohol resulted in some 3 million deaths (5.3% of all deaths) worldwide and 132.6 million DALYs (5.1% of all DALYs). Mortality from alcohol consumption is higher than from diseases such as tuberculosis, HIV/AIDS and diabetes. In 2016, an estimated 2.3 million deaths and 106.5 million DALYs among men globally were attributable to alcohol consumption. For women, the figures were 0.7 million and 26.1 million, respectively. Worldwide, in 2016, alcohol was responsible for 7.2% of all premature mortality (in persons aged 69 years or less). Younger people were disproportionately affected by alcohol; 13.5% of all deaths among 20–39-year-olds in 2016 were attributed to alcohol.

In 2016, the age-standardized alcohol-attributable burden of disease and injury was highest in the African Region, whereas the proportions of all deaths and DALYs attributable to alcohol consumption were highest in the European Region (10.1% of all deaths and 10.8% of all DALYs) followed by the Region of the Americas (5.5% of deaths and 6.7% of DALYs). Approximately 49% of alcohol-attributable DALYs are due to NCDs and mental health conditions, and about 40% are due to injury.

According to the latest WHO global estimates, 283 million people aged 15 years and older – 237 million men and 46 million women – live with alcohol use disorders (AUD), accounting for 5.1% of the global adult population. Alcohol dependence, as the most severe form of AUD, affects 2.6% of the world's adults, or 144 million people.

The impact of the harmful use of alcohol on health and well-being is not limited to health consequences; it incurs significant social and economic losses relating to costs in the justice sector, costs from lost workforce productivity and unemployment, and costs assigned to pain and suffering. The harmful use of alcohol can also result in harm to others, such as family members, friends, co-workers and strangers. The harms to others may be concrete (e.g. injuries or damages) or may result from suffering, poor health and well-being, and the social consequences of drinking (e.g. being harassed or insulted, or feeling threatened).

Overall – ~~despite some~~ ~~in light of~~ decreasing trends in ~~the harmful use of alcohol consumption and in alcohol-related harm~~ in some segments of the population, improvements in some indicators of the disease burden attributable to alcohol consumption, and alcohol policy developments at national level – the implementation of the Global Strategy has ~~not~~ resulted in ~~considerable~~ reductions in ~~the harmful use of alcohol~~, alcohol-related morbidity and mortality and the ensuing social consequences ~~in line with or exceeding the NCD target of a 10% reduction in the harmful use of alcohol by 2025~~. Globally, the levels of ~~harmful use of alcohol consumption~~ and alcohol-attributable harm continue to be unacceptably high. The impact of the COVID-19 pandemic on the levels and patterns of alcohol consumption and related harm worldwide still need to be assessed.

Challenges in implementation of the Global Strategy

Considerable challenges remain for the development and implementation of effective alcohol policies. These challenges relate to the complexity of the problem, differences in cultural norms and contexts, and the intersectoral nature of cost-effective solutions and associated limited levels

of political will and leadership at the highest levels of governments, as well as the influence of [some](#) powerful commercial interests in policy-making and implementation. These challenges operate against a background of competing international economic commitments. Responsibility for dealing with these various challenges is dispersed between different entities – including government departments, different professions and technical areas – which complicates coordination and cooperation at all levels.

The drinking of alcoholic beverages is strongly embedded in the social norms and cultural traditions of many societies. Prevailing social norms that support drinking behaviour and mixed messages about the harms and benefits of drinking may encourage alcohol consumption, delay appropriate health-seeking behaviour and weaken community action. The accumulated evidence indicates that [the harmful use of alcohol consumption](#) is associated with inherent health risks, although these risks vary significantly in magnitude and health consequences among drinkers. Awareness and acceptance of the overall negative impact of [the harmful use of alcohol consumption](#) on a population's health and safety is low among decision-makers and the general public. This is influenced by commercial messaging and poorly-regulated marketing of alcoholic beverages which deprioritize efforts to counter the harmful use of alcohol in favour of other public health issues.

The production of alcoholic beverages has become increasingly concentrated and globalized in recent decades, particularly in the [beer and spirits sectors](#), whereas [the brewing sector has experienced the booming of small producers across the globe](#). A significant proportion of alcoholic beverages is consumed in heavy drinking occasions and by people affected by AUD, illustrating the inherent contradiction between the interests of [some](#) alcohol producers and public health. Strong international leadership is needed to counter interference of [undue](#) commercial interests in alcohol policy development and implementation in order to prioritize the public health agenda for alcohol in the face of a strong global industry and commercial interests. [In some respects, commercial interests align with public health interest where voluntary commitments of producers are leading to enhanced information to consumers \(for example, the commitment to provide ingredient and nutrient information on the label by the beer sector\) and where the development and marketing of no-alcohol or lower strength alcohol products leads to decreased overall alcohol consumption.](#)

Competing interests across the whole of government at the country level, including interests related to the production and trade of alcohol and government revenues from alcohol taxation and sales, often result in policy incoherence and the weakening of alcohol control efforts. The situation varies at national and subnational levels and is heavily influenced by the commercial interests of [some](#) alcohol producers and distributors, religious beliefs, and spiritual and cultural norms. However, general trends towards deregulation in recent decades have often resulted in a weakening of alcohol controls, to the benefit of [some](#) economic interests and to the expense of public health and welfare.

Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. This absence [may limit](#) the ability of [some](#) national and subnational governments to regulate the distribution, sale and marketing of alcohol within the context of international, regional and bilateral trade negotiations, as well as to protect the development of alcohol policies from interference by [some](#) transnational corporations and [some](#) commercial interests. This prompted calls [by a limited number of governments](#) for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control, and discussions about the feasibility and necessity of such a legally binding international instrument. [Those calls were rejected by a majority of governments who consider they have full ability to regulate the distribution, sale and marketing of alcohol.](#)

Informally and illegally produced alcohol account for an estimated 25% of total alcohol

consumption per capita worldwide and, in some jurisdictions, exceed half of all alcohol consumed by the population. Informal and illegal production and trade are different in nature and require different policy and programme responses. Informal production and distribution of alcohol are often embedded in cultural traditions and socioeconomic fabrics of communities. Illicit alcohol production is associated with significant health risks and challenges for regulatory and law enforcement sectors of governments. The capacity to deal with informal or illicit production, distribution and consumption of alcohol, including safety issues, is limited or inadequate,

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particularly in jurisdictions where unrecorded alcohol makes up a significant proportion of all alcohol consumed.

Satellite and digital marketing [may](#) present a growing challenge for the effective control of alcohol marketing and advertising [if not correctly managed](#). Alcohol producers and distributors have increasingly moved to investing in digital marketing and using social media platforms, which are profit-making businesses with an infrastructure designed to allow “native advertising” that is data-driven and participatory. Internet marketing crosses borders with even greater ease than satellite television and is not easily subjected to national-level control. In parallel with the greater opportunity for marketing and selling alcohol through online platforms, delivery systems are rapidly evolving, imposing considerable challenges on the ability of governments to control alcohol sales [if not correctly managed](#).

Limited technical capacity, human resources and funding hinder efforts in developing, implementing, enforcing and monitoring effective alcohol control interventions at all levels. Technical expertise in alcohol-control measures is often absent at national and subnational levels and sufficient human and financial resources for the provision of essential technical assistance and compilation, dissemination and application of technical knowledge into practice have been grossly insufficient in WHO at all levels. Few civil society organizations prioritize alcohol as a health risk or motivate governments into action compared to organizations that support tobacco control. In the absence of philanthropic funding, and with limited resources in WHO and other intergovernmental organizations, there has been little investment in capacity-building in low- and middle-income countries.

The lack of sufficiently developed national systems for monitoring [the harmful use of alcohol](#), alcohol consumption and the impact of alcohol on health reduces the capacity of advocacy for effective alcohol-control policies and for monitoring their implementation and impact.

Opportunities for reducing the harmful use of alcohol

Uneven and insufficient progress with implementation of the Global Strategy can be addressed by actions which are built on existing and emerging opportunities for reducing the harmful use of alcohol.

In recent years, alcohol consumption among young people has decreased in many countries throughout Europe and in some other high-income societies, with the exception of some disadvantaged groups. The decline seems to be continuing into the next age group as the cohort ages. Capitalizing on this trend offers a considerable opportunity for public health policies and programmes. There is also a trend towards an increase in the proportion of former drinkers among people aged 15 years and above. One contributory factor is the increasing awareness of negative health and social consequences of the harmful use of alcohol, and alcohol’s causal relationships with some types of cancer, liver and cardiovascular diseases, as well as its association with increased risk of infectious diseases such as tuberculosis and HIV/AIDS. Increasing the health literacy and health consciousness of the general public provides an opportunity for strengthening prevention activities and scaling up screening and brief interventions in health services.

While recognizing its negative influences and effects, social media also provides new opportunities for changing peoples’ relationship with alcohol through increased awareness of the negative health consequences of [the harmful use of alcohol](#)~~drinking~~, and new horizons for communication and promotion of recreational activities as an alternative to drinking and intoxication. At the same time, social media can serve as a powerful source of marketing communication and brand promotion for alcoholic beverages.

[The harmful alcohol use](#) and its impact on health have been increasingly recognized as factors in health inequality. Within a given society, adverse health impacts and social harm from a given level and pattern of drinking are greater for poorer individuals and societies. Increased alcohol consumption can exacerbate health and social inequalities between genders as well as social classes. Policies and programmes to reduce health inequalities and promote sustainable development need to include sustained attention to alcohol policies and programmes.

The body of evidence for the effectiveness and cost-effectiveness of alcohol control measures has been significantly strengthened in recent years. The latest economic analysis undertaken under the auspices of WHO demonstrated high returns on investment for “best buys” in alcohol control. Every additional United States dollar invested in the most cost-effective interventions per person per year will yield a return of US\$ 9.13 by 2030, a return that is higher than a similar investment in tobacco control (US\$ 7.43) or prevention of physical inactivity (US\$ 2.80).

The COVID-19 pandemic and measures to curb virus transmission (lockdowns, stay-at-home mandates) have had a significant impact on population health and well-being, as well as on patterns of alcohol consumption, alcohol-related harms and the effectiveness of existing policy and programme responses. The COVID-19 outbreak has underscored the importance of developing appropriate alcohol policy responses, alcohol-focused activities and interventions during public health emergencies. This will have important implications for reducing not only the harmful use of alcohol at national, regional and global levels, but also the alcohol-related health burden and demand for health service interventions during the pandemic.

SCOPE OF THE ACTION PLAN

The Global Strategy to Reduce the Harmful Use of Alcohol was recognized by WHO Member States at the 146th session of the Executive Board (2020) (Annex 2) as continuing to be relevant (a report on a review of the Global Strategy will be submitted in 2030), but resources and capacities for its implementation in WHO and some Member States do not correspond to the magnitude of the health and social burden. Alcohol marketing, advertising and promotional activities of alcoholic beverages are of deep concern, including those implemented through cross-border marketing, and targeting young people and adolescents. The development of an action plan (2022–2030) was requested by the decision of the WHO Executive Board to implement the Global Strategy as a public health priority. When endorsing the Global Strategy in 2010, the World Health Assembly affirmed that it aims to give guidance for action at all levels and to set priority areas for global action. The Strategy also provides a portfolio of policy options and measures that could be considered for implementation at the national level at the discretion of each Member State, depending on national contexts, priorities and resources. As stated in paragraph 59 of the Global Strategy, its successful implementation requires concerted actions by Member States, effective global governance and appropriate engagement of all relevant stakeholders. Hence, the proposed scope of key elements for developing the action plan includes specific actions and measures to be implemented at global level, in line with key roles and components of global action as formulated in the Global Strategy. The action plan will also include proposed actions for Member States, international partners and non-State actors to be considered for implementation at the national level. The action plan contains specific targets, indicators and proposed actions for all stakeholders, developed on the basis of lessons learned from implementation of the Global Strategy over the last 10 years, and with a timeline extended to 2030 in line with the timeline of the 2030 Agenda for Sustainable Development. The action plan is linked to and aligned with other relevant global action plans, including the Mental health action plan, the Global action plan for prevention and control of NCDs, the Global action plan on the public health response to dementia, and the Global plan of action to address interpersonal violence.

WHO aims to ensure that by 2023 1 billion more people enjoy better health and well-being, 1 billion more people are better protected from health emergencies and a further 1 billion more people benefit from universal health coverage. These goals indicate strategic directions for WHO in protecting and promoting population health worldwide. In the context of reducing the harmful use of alcohol, these goals can be translated into the objectives of: 1) increasing the proportion of populations that are protected from the harmful use of alcohol by effective alcohol control policies; 2) increasing the capacity of countries to address the harmful use of alcohol during health emergencies (such as the COVID-19 pandemic) by appropriate policy and programme responses; and 3) increasing the proportion of people with AUD and comorbid conditions benefitting from universal health coverage.

GOAL OF THE ACTION PLAN

The goal of the action plan is to boost effective implementation of the Global Strategy as a public health priority and considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.

Effective implementation of the action plan at regional levels may require development or elaboration and adaptation of region-specific action plans. Emphasis is also needed on coordination within the Secretariat so that all actions aimed at reducing the harmful use of alcohol are in line with the Global Strategy and the action plan to strengthen its implementation.

PROPOSED OPERATIONAL OBJECTIVES FOR THE ACTION PLAN, GUIDING PRINCIPLES AND KEY AREAS FOR GLOBAL ACTION

The proposed operational objectives of the action plan 2022–2030 and the proposed action areas are based on the objectives of the Global Strategy (Box 2) and the four key components of global action to reduce the harmful use of alcohol effectively (Box 3). However, the proposed operational objectives of the action plan are not identical to those of the Global Strategy. This reflects the action-oriented nature of the action plan, as well as more recent goals and objectives of other relevant global strategies and action plans, and lessons learned in implementing the Global Strategy since its endorsement.

Box 2. Objectives of the Global Strategy to Reduce the Harmful Use of Alcohol (WHO, 2010)

- (a) 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;
- (b) strengthened knowledge base on the magnitude and determinants of alcohol-related harm and on effective interventions to reduce and prevent such harm;
- (c) 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;
- (d) 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;

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

It is widely acknowledged that implementation of the Global Strategy is uneven, and the overall burden of disease and injuries attributable to alcohol consumption remains unacceptably high. Substantial progress with attainment of the goal and objectives of the Global Strategy can be achieved only through implementation of high-impact cost-effective alcohol control measures from the 10 target areas recommended in the Global Strategy for national policies and interventions (Box 4) at the national level. These target areas are not only supportive of and complementary to each other, but are strongly interlinked with the four components for global action.

Box 3. Global action: key components (Global Strategy to Reduce the Harmful Use of Alcohol. WHO, 2010)

- 1. Public health advocacy and partnership.** International public health advocacy and partnership are needed for strengthened commitment and abilities of the governments and all relevant parties at all levels for reducing the harmful use of alcohol worldwide.
- 2. Technical support and capacity-building.** Many Member States need increased capacity and capability to create, enforce and sustain the necessary policy and legal frames and implementation mechanisms. Global action will support national action through the development of sustainable mechanisms and the provision of the necessary normative guidance and technical tools for effective technical support and capacity-building, with particular focus on developing and low- and middle-income countries.
- 3. Production and dissemination of knowledge.** Important areas for global action will be monitoring trends in alcohol consumption, alcohol-attributable harm and the societal responses, analysing this information and facilitating timely dissemination. Available knowledge on the magnitude of harmful use of alcohol, and effectiveness and cost-effectiveness of preventive and treatment interventions should be further consolidated and expanded systematically at the global level, especially information on epidemiology of alcohol use and alcohol-related harm, impact of harmful use of alcohol on economic and social development and the spread of infectious diseases in developing and low- and middle-income countries.
- 4. Resource mobilization.** The magnitude of alcohol-attributable disease and social burden is in sharp contradiction with the resources available at all levels to reduce harmful use of alcohol. Global development initiatives must take into account that developing and low- and middle-income countries need technical support – through aid and expertise – to establish and strengthen national policies and plans for the prevention of harmful use of alcohol and develop appropriate infrastructures, including those in health-care systems.

Box 4. Recommended target areas for policy measures and interventions at the national level (Global Strategy to Reduce the Harmful Use of Alcohol. WHO, 2010)

Area 1. Leadership, awareness and commitment

Area 2. Health services' response

Area 3. Community action

Area 4. Drink-driving policies and countermeasures

Area 5. Availability of alcohol

Area 6. Marketing of alcoholic beverages

Area 7. Pricing policies

Area 8. Reducing the negative consequences of drinking and alcohol intoxication

Area 9. Reducing the public health impact of illicit alcohol and informally produced alcohol

Area 10. Monitoring and surveillance

Operational objectives of the action plan:

1. Increase population coverage and implementation of high-impact policy options and interventions to reduce the harmful use of alcohol worldwide for better health and well-being.
2. Strengthen multisectoral action through effective governance, enhanced political commitment and leadership, dialogue and coordination of multisectoral action.
3. Enhance prevention and treatment capacity of health and social care systems for disorders due to alcohol use and associated health conditions as an integral part of universal health coverage and aligned with the 2030 Agenda for Sustainable Development and its health targets.
4. Raise awareness of risks and harms associated with [the harmful use of alcohol consumption](#) at all levels as well as of effectiveness of different policy options to reduce [the harmful use of alcohol consumption](#) and related harm.
5. Strengthen information systems and research for monitoring alcohol consumption, alcohol-related harm and policy responses at all levels with dissemination and application of information for advocacy, policy development and evaluation purposes.
6. Significantly increase mobilization of resources required for appropriate and sustained action to reduce the harmful use of alcohol at all levels.

Operational principles for global action:

The Global Strategy includes guiding principles for the development and implementation of alcohol policies at all levels (Box 5). The guiding principles listed in the Strategy can be complemented by operational action-oriented principles to be included in the global action plan. The following principles and approaches are presented here for consideration:

- Multisectoral action
- Universal health coverage
- Life course approach
- Protection from [undue](#) commercial interests
- Evidence-based approach
- Equity-based approach

- Human rights approach
- Empowering of people and communities

Box 5. Guiding principles (Global Strategy to Reduce the Harmful Use of Alcohol. WHO, 2010)

Principle 1 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.

Principle 2 Policies should be equitable and sensitive to national, religious and cultural contexts.

Principle 3 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.

Principle 4 Public health should be given proper deference in relation to competing interests and approaches that support that direction should be promoted.

Principle 5 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.

Principle 6 Individuals and families affected by the harmful use of alcohol should have access to affordable and effective prevention and care services.

Principle 7 Children, teenagers and adults who choose not to drink alcoholic beverages have the right to be supported in their nondrinking behaviour and protected from pressures to drink.

Principle 8 Public policies and interventions to prevent and reduce alcohol-related harm should encompass all alcoholic beverages and surrogate alcohol.

Key areas for global action:

To achieve the above-mentioned goal and objectives, the following key areas are proposed for action by Member States, the WHO Secretariat, international and national partners and, as appropriate, other stakeholders:

Action area 1: Implementation of high-impact strategies and interventions

Action area 2: Advocacy, awareness and commitment

Action area 3: Partnership, dialogue and coordination

Action area 4: Technical support and capacity-building

Action area 5: Knowledge production and information systems

Action area 6: Resource mobilization.

The first action area, focusing on implementation of high-impact, cost-effective interventions summarized in the WHO SAFER technical package, is the key for successful achievement of the global action plan goal: to reduce considerably morbidity and mortality due to alcohol use over and above general morbidity and mortality trends.

ACTION AREA 1: IMPLEMENTATION OF HIGH-IMPACT STRATEGIES AND INTERVENTIONS

Limited global progress achieved so far in reducing the harmful use of alcohol (or no progress at all in some parts of the world) can be explained by insufficient uptake, implementation and enforcement of the most effective and cost-effective alcohol policies and interventions. The goal of considerably reducing morbidity and mortality due to alcohol use over and above general morbidity and mortality trends and associated social consequences can be achieved by increasing population coverage and strengthening implementation of measures with proven effectiveness that can be implemented in countries with different levels of available resources.

The WHO-led SAFER initiative is based on effective and cost-effective policy options and interventions which are summarized in Appendix 3 of the Global Action Plan for the Prevention and Control of NCDs and endorsed by the 70th World Health Assembly. The SAFER initiative includes the following policy options and interventions:

- Strengthen restrictions on alcohol availability
- Advance and enforce drink-driving countermeasures
- Facilitate access to screening, brief interventions and treatment
- Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion
- Raise prices on alcohol through excise taxes and other pricing policies.

Global targets for Action area 1

Global target 1.1: By 2030, 75% of countries have ~~introduced and/or strengthened and~~ sustainably enforced implementation of high-impact policy options and interventions.¹

Global target 1.2: At least a x% relative reduction in ~~the harmful use of~~ alcohol ~~per capita~~ (among those aged 15 years and older) ~~consumption~~ by 2025 and a x% relative reduction by 2030.²

Global target 1.3: By 2030, 80% of the world's population are protected from the harmful use of alcohol by sustained implementation and enforcement of high-impact policy options with due consideration of national contexts, priorities and available resources.

¹ Included in the SAFER technical package.

² The target figures for this indicator are to be defined on the basis of analysis of the WHO data on alcohol consumption.

Proposed actions for Member States

- Action 1.** Based on the evidence of effectiveness and cost-effectiveness of policy measures, to prioritize sustainable implementation, continued enforcement, monitoring and evaluation of high-impact policy options included in the WHO SAFER technical package.
- Action 2.** Ensure that development, implementation and evaluation of alcohol policy measures are based on public health goals and the best available evidence and are protected from interference from [undue](#) commercial interests.
- Action 3.** Strengthen or develop national systems to monitor implemented alcohol policy measures and interventions in conjunction with monitoring [the harmful use of alcohol](#), alcohol consumption and related harm to assess the impact of implemented policy measures and interventions.
- Action 4.** Build or strengthen and support broad partnerships and intragovernmental and intergovernmental mechanisms for collaboration across different sectors for implementation of high-impact policy options.

Proposed actions for the WHO Secretariat

- Action 1.** Provide policy guidance, advocacy and, as required, technical assistance for the development, implementation and evaluation of effective and cost-effective policy options, and continue to lead implementation of the SAFER initiative in collaboration with WHO partners.
- Action 2.** Periodically review the evidence of effectiveness and cost-effectiveness of alcohol policy options and interventions and formulate and disseminate recommendations for reducing the harmful use of alcohol.
- Action 3.** Further develop and strengthen broad international partnerships on reducing the harmful use of alcohol and support international mechanisms for intersectoral collaboration with United Nations entities, civil society, academia and professional organizations.
- Action 4.** Maintain dialogues with representatives of economic operators in the area of alcoholic beverage production and trade on how they can best contribute to the reduction of alcohol-related harm within their core roles.
- Action 5.** Strengthen global monitoring of implementation of the Global Strategy and the proposed action plan to reduce the harmful use of alcohol with a focus on high-impact strategies and interventions and report periodically on progress achieved.³

Proposed actions for international partners and non-State actors

- Action 1.** Major partners within the United Nations system and intergovernmental organizations are invited to increase collaboration and cooperation with WHO on the development, implementation and evaluation of high-impact policy measures, and by joining the WHO-led SAFER initiative.
- Action 2.** Civil society organizations and academia are invited to strengthen advocacy and support for implementation of high-impact policy options by creating enabling environments, promoting the SAFER initiative, strengthening global and regional networks and action groups, developing and strengthening accountability frameworks, and monitoring activities and commitments of economic operators in alcohol production and trade.
- Action 3.** Economic operators in alcohol production and trade are invited to focus on their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages, and refrain from activities that may prevent, delay or stop the development, enactment and enforcement of high-impact strategies and interventions to reduce the harmful use of alcohol. Economic operators in alcohol production and trade, as well as economic operators in other relevant sectors (such as retail, advertisements, social media and communication), are encouraged to contribute to the elimination of marketing and sales of alcoholic beverages to minors and targeted commercial activities towards other high-risk groups.

³ Proposed indicators for monitoring implementation of high-impact interventions are included in Annex 1.

ACTION AREA 2: ADVOCACY, AWARENESS AND COMMITMENT

Strategic and well-developed international communication and advocacy are needed to raise awareness about alcohol-related harm and the effectiveness of policy measures among decision-makers and the general public in order to increase their support for faster implementation of the Global Strategy. Special efforts and activities are needed to mobilize different stakeholders for coordinated actions to protect public health and foster broad political commitment to reduce the harmful use of alcohol.

It is necessary to raise awareness among decision-makers and the general public about the risks and harms associated with alcohol consumption. Appropriate attention should be given to preventing the initiation of drinking among children and adolescents and protecting people from pressures to drink, especially in societies with high levels of alcohol consumption where heavy drinkers are encouraged to drink even more. An international day of awareness on the harmful use of alcohol or a “World no alcohol day” could help to focus and reinforce public attention on the problem. Public health advocacy is more likely to succeed if it is well supported by evidence and based on emerging opportunities, and if the arguments are free from moralizing. The international discourse on alcohol policy development and implementation should not be limited to NCDs but should be expanded to include other areas of health and development such as injuries, violence, infectious diseases and a “harm to others” perspective. Modern communication technologies and multimedia materials are needed for successful advocacy and behavioural change campaigns, including social media engagement.

Such awareness, along with the development and enforcement of alcohol policies, needs to be protected from interference by commercial interests. Appropriate mechanisms that involve academics and civil society must be set up to systematically monitor such interference and activities of the industry.

Global targets for Action area 2

Global target 2.1: By 2030, 75% of countries have developed and enacted a written national alcohol policy that is based on best available evidence and supported by legislative measures for effective implementation of high-impact strategies and interventions.

Global target 2.2: By 2030, 50% of countries are periodically producing national reports on [the harmful use of alcohol](#), alcohol consumption, alcohol-related harm and effective policy responses targeting decision-makers and the general public.

Proposed actions for Member States

- Action 1.** Based on evidence of the nature and magnitude of alcohol-attributable public health problems, advocate for the development and implementation of high-impact strategies, interventions and other actions to prevent and reduce alcohol-related harm. This includes a special emphasis on protecting at-risk populations and those affected by the harmful drinking of others, preventing initiation of drinking among children and adolescents, and reducing the levels of [harmful use of alcohol consumption](#) among drinkers.
- Action 2.** Develop, strengthen and update as necessary and implement national alcohol policies with legislative measures to support high-impact strategies and interventions.
- Action 3.** Advocate for appropriate attention, congruous with the magnitude of related public health problems, to reducing the harmful use of alcohol in multisectoral policies and frameworks as well as in national, economic, environmental, agricultural and other relevant policies and action plans.
- Action 4.** Include a commitment to reduce the harmful use of alcohol and its impact on health and well-being in high-level national developmental and public health strategies, programmes and action plans, and support the creation and development of advocacy coalitions.
- Action 5.** Regularly produce national reports on [the harmful use of alcohol](#), alcohol consumption and alcohol-related harm targeting decision-makers and the general public with information on alcohol's contribution to specific health

and social problems and dissemination of information through available modern communication technologies.

Action 6. Increase awareness of the health risks of [the harmful use of alcohol use](#) and related overall impact on health and well-being through strategic, well-developed and long-term communication activities, including an option of a national alcohol awareness day to be implemented by public health agencies and organizations and involving countering misinformation and using targeted communication channels, including social media platforms.

~~**Action 7.** Ensure appropriate consumer protection measures through development and implementation of labelling requirements for alcoholic beverages which display essential information on ingredients, caloric value and health warnings.~~

Action 8. Support education, training and networking activities on reducing the harmful use of alcohol for representatives of authorities at different levels, health professionals, civil society organizations and the media.

Commented [M3]: This is outside the remit of the WHO and dealt with by Codex Alimentarius (for setting standards) and Member States who are responsible for defining rules at national level.

Proposed actions for the WHO Secretariat

Action 1. Raise the priority given to the alcohol-attributable health and social burden and effective policy responses in the agendas of high-level global, regional and other international forums, meetings and conferences of international and intergovernmental organizations, professional associations and civil society groups, and seek inclusion of alcohol policies in relevant social and development agendas.

Action 2. Continue monitoring the magnitude of public health problems caused by the harmful use of alcohol by collecting relevant information from Member States, international agencies and other information sources, and supporting estimates of alcohol-attributable disease burden at global, regional and subregional levels.

Action 3. Develop and implement an organization-wide communication plan to support actions to reduce the harmful use of alcohol reflecting emerging challenges (such as the COVID-19 pandemic), targeting different population groups and using different communication channels.

Action 4. Prepare and disseminate every 4–5 years global status reports on alcohol and health to raise awareness of the alcohol-attributable burden and advocate for appropriate action at all levels.

Action 5. Develop, test and disseminate technical and advocacy tools for effective communication of consistent, scientifically sound and clear messages about alcohol-attributable health and social problems and effective policy and programme responses. Review, update and disseminate WHO nomenclature and definitions of alcohol-related terms, particularly in the area of alcohol policy and monitoring.

~~**Action 6.** Develop the international standards for labelling of alcoholic beverages to inform consumers about the content of the products and the health risks associated with their consumption.~~

Action 7. To facilitate dialogue and information exchange regarding the impact of international aspects of the alcohol market on the alcohol-attributable health burden, advocate for appropriate consideration of these aspects by parties in international trade negotiations and seek international solutions within the WHO's mandate if appropriate actions to protect the health of populations cannot be implemented.

Commented [M4]: This is outside the remit of the WHO and dealt with by Codex Alimentarius (for setting standards) and Member States who are responsible for defining rules at national level.

Proposed actions for international partners and non-State actors

Action 1. Major partners within the United Nations system and intergovernmental organizations are invited to include activities for reducing the harmful use of alcohol in their agendas and ensure support for policy coherence between health and other sectors in international multisectoral policies, strategies and frameworks, as well as proper deference of public health interests in relation to competing interests.

Action 2. Civil society organizations, professional associations and academia are invited to scale up their activities in support of global, regional and national awareness and advocacy campaigns, as well as in countering misinformation about [the harmful use of alcohol use](#) and its associated health risks. They are also invited to motivate and engage different stakeholders, as appropriate, in the implementation of effective strategies and interventions to reduce the harmful use of alcohol, and to monitor activities which undermine effective public health measures.

Action 3. Economic operators in alcohol production and trade as well as operators in other relevant sectors of the economy are invited to take concrete steps, where relevant, towards eliminating the marketing and advertising of alcoholic products to minors, ~~refrain eliminate from the promotion of irresponsible drinking~~, eliminate and prevent any ~~illegal and non-evidence-based positive~~ health claims, and ensure, within co-regulatory frameworks, the availability of easily-understood consumer information on the labels of alcoholic beverages (including composition, age limits, health [warning information](#) and contraindications for alcohol use).

ACTION AREA 3: PARTNERSHIP, DIALOGUE AND COORDINATION

New partnerships and the appropriate engagement of all relevant stakeholders are needed to build capacity and support implementation of practical and focused technical packages that can ensure returns on investments within a “Health for All” approach. Increased coordination between health and other sectors such as finance, transport, communication and law enforcement is required for implementation of effective multisectoral measures to reduce the harmful use of alcohol. The new WHO-led SAFER initiative and partnership to promote and support implementation of “best buys”, alongside other recommended alcohol-control measures at the country level, can invigorate action in countries through coordination with WHO’s partners within and outside the United Nations system. Effective alcohol control requires a “whole of government” and “whole of society” approach with clear leadership by the public health sector and appropriate engagement of other governmental sectors, civil society organizations, academic institutions and, as appropriate, the private sector. There is a need to strengthen the role of civil society in alcohol policy development and implementation.

Global and regional networks of country focal points and WHO national counterparts for reducing the harmful use of alcohol, as well as technical experts, will facilitate country cooperation, knowledge transfer and capacity-building. The technical networks and platforms should focus on particularly challenging technical areas and situations such as the control of digital marketing, social media advertising or reducing the harmful use of alcohol during health emergencies such as the COVID-19 pandemic.

The continuing global dialogue with economic operators in alcohol production and trade should focus on the industry’s contribution to reducing the harmful use of alcohol in their roles as developers, producers and distributors/sellers of alcoholic beverages. This dialogue should also aim for implementation of comprehensive restrictions or bans on traditional, online or digital marketing (including sponsorship), as well as on sales, e-commerce, delivery, product formulation and labelling, and data on production and sales. The dialogue should engage, as appropriate, economic operators in other sectors of the economy directly involved in distribution, sales and marketing of alcoholic beverages.

Global targets for Action area 3

Global target 3.1: x%⁴ of countries have established and functioning national and subnational multisectoral coordination mechanisms for implementation and strengthening of effective alcohol control measures.

Global target 3.2: 75% of countries are engaged in and contribute to the work of the global and regional networks of WHO national counterparts for international dialogue and coordination on reducing the harmful use of alcohol.

Proposed actions for Member States

Action 1. Encourage mobilization and active and appropriate engagement of all relevant entities and groups in reducing the harmful use of alcohol, and also by advocating for appropriate coordination mechanisms,

⁴ A target figure to be defined on the basis of reanalysis of the WHO global SDG health target 3.5 survey implemented in 2019–2020.

strategies and action plans in the context of the 2030 Agenda for Sustainable Development, taking into consideration any stakeholder conflicts of interests.

- Action 2.** Ensure effective national governance and coordination of activities of all relevant stakeholders in the implementation of national strategies, action plans and policies to reduce the harmful use of alcohol.
- Action 3.** Collaborate with the WHO Secretariat on implementation of the Global Strategy and through representation in WHO's global and regional networks of national counterparts and (technical) contributions to their working mechanisms, processes and structures.
- Action 4.** Document and share experiences and information on the development, implementation and evaluation of multisectoral actions to reduce the harmful use of alcohol at national and subnational levels.

Actions for the Secretariat

- Action 1.** Liaise and cooperate with major partners within the United Nations system and intergovernmental organizations, and coordinate and develop collaborative activities through the functioning of interagency working mechanisms on reducing harmful use of alcohol, including those established for Mental Health and Noncommunicable Diseases.
- Action 2.** To provide support to the global and regional networks of WHO national counterparts and their working mechanisms and procedures by ensuring regular information exchange and their effective functioning. This includes the working groups or task teams addressing priority areas for reducing the harmful use of alcohol.
- Action 3.** To facilitate dialogue and information exchange on the impact of international aspects of the alcohol market on the alcohol-attributable health burden and advocate for appropriate consideration of these aspects by parties in international trade negotiations.
- Action 4.** To support international collaboration and information exchange among public health-oriented NGOs, academic institutions and professional associations, with a special focus on facilitating multisectoral collaboration, ensuring policy coherence (with due consideration of differences in cultural contexts), and support for strengthening the contributions of civil society organizations to alcohol policy development and implementation.
- Action 5.** Every second year organize an international forum on reducing the harmful use of alcohol within the WHO Forum on alcohol, drugs and addictive behaviours (FADAB) with participation of representatives of Member States, United Nations entities and other intergovernmental and international organizations, civil society organizations, [economic operators](#) and professional associations, and support broader representation of civil society organizations from low- and middle-income countries.
- Action 6.** Organize regular (each year or every second year, as required) global dialogues with economic operators in alcohol production and trade focused on and limited to the industry's contribution to reducing the harmful use of alcohol within their roles as developers, producers and distributors/sellers of alcoholic beverages.

Proposed actions for international partners and non-State actors

- Action 1.** Major partners within the United Nations system and intergovernmental organizations are invited to include, as appropriate, implementation of the Global Strategy in their developmental strategies and action plans, and to develop horizontal multisectoral programmes and partnerships to reduce the harmful use of alcohol as a public health priority, in line with the guiding principles of the Global Strategy.
- Action 2.** Civil society organizations, professional associations and academia are invited to prioritize and strengthen their activities on reducing the harmful use of alcohol, by motivating and engaging their stakeholders in implementation of the Global Strategy within existing partnerships or by developing new collaborative frameworks, and by promoting and supporting, within their roles and mandates, intersectoral and multisectoral collaboration and dialogue while monitoring and countering undue influences from commercial vested interests that undermine attainment of public health objectives.
- Action 3.** Economic operators in alcohol production and trade are invited to focus on their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages, and abstain from interfering with alcohol policy development and evaluation.

ACTION AREA 4: TECHNICAL SUPPORT AND CAPACITY-BUILDING

There is a need to increase the capacity and capability of countries to create, enforce and sustain the necessary policy and legislative frameworks, develop infrastructure and sustainable mechanisms for their implementation at national and subnational levels, and ensure that implemented strategies and interventions are based on the best available scientific evidence and best practices of their implementation accumulated in different cultural, economic and social contexts. Implementation of alcohol policy measures at the country level according to the national contexts, needs and priorities may require strong technical assistance, particularly in less-resourced countries and in technical areas such as taxation, legislation, regulations for digital marketing and their enforcement, or consideration of health protection from alcohol-related harm in trade negotiations.

Global targets for Action area 4

Global target 4.1: 50%⁵ of countries have increased capacity and infrastructure for implementation of high-impact strategies and interventions to reduce the harmful use of alcohol.

Global target 4.2: 50%⁶ of countries have increased capacity to provide prevention and treatment interventions for health conditions due to [harmful use of alcohol](#) ~~use~~ in line with the principles of universal health coverage.

Proposed actions for Member States

- Action 1.** Develop or strengthen technical capacity and infrastructure, including involvement of public health civil society organizations, for implementation of high-impact strategies and interventions to reduce the harmful use of alcohol and, when appropriate, collaborate with the WHO Secretariat on testing, dissemination, implementation and evaluation of WHO technical tools, recommendations and training materials.
- Action 2.** Document and share, in collaboration with WHO, good practices and examples of policy responses and implemented measures to reduce harmful use of alcohol in different socioeconomic and cultural contexts according to the 10 recommended target areas for policy options and interventions included in the Global Strategy.
- Action 3.** Develop or strengthen the capacity of health professionals in health and social care systems to prevent, identify and manage hazardous drinking⁷ and disorders due to alcohol use, and develop the capacity of health and social care systems to ensure universal health coverage for people with alcohol use disorders and comorbid health conditions.
- Action 4.** Support capacity-building of health professionals, public health experts and representatives of civil society organizations, including mutual help groups and associations of affected individuals and their family members, to advocate for, implement, enforce and sustain implementation of effective measures to reduce the harmful use of alcohol, including support of education and training programmes.

⁵ This figure is indicative and subject to adjustment after reanalysis of data from the relevant WHO surveys. The baseline for this indicator is the year of endorsement of the action plan.

⁶ This figure is indicative and subject to adjustment after reanalysis of data from the relevant WHO surveys. The baseline for this indicator is the year of endorsement of the action plan.

⁷ In ICD-11 “hazardous alcohol use” is defined as a “pattern of alcohol use that appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals” (WHO, 2019).

Actions for the Secretariat

- Action 1.** Collect, compile and disseminate through WHO information channels at global and regional levels good practices and examples of policy responses and implemented measures to reduce the harmful use of alcohol in Member States from around the world according to the 10 recommended target areas for policy options and interventions, including legislative provisions; and develop and maintain global and regional repositories of good practice and examples.
- Action 2.** Foster and strengthen global and regional networks of national technical counterparts by developing capacity-building platforms in partnership with academia and civil society organizations with a focus on particularly challenging areas such as: 1) digital marketing and social media advertising; 2) protecting alcohol control within the context of supranational regulatory and legislative frameworks; 3) strengthening health service and social care responses; and 4) building up national monitoring systems on alcohol and health.
- Action 3.** Develop, test and disseminate global evidence-based and ethical recommendations, standards, guidelines and technical tools, including a protocol for comprehensive assessment of alcohol policies; propose, as deemed necessary and according to WHO procedures, other normative or technical instruments to provide normative and technical guidance on effective and cost-effective prevention and treatment interventions in different settings; and provide support to Member States in implementing the Global Strategy according to the 10 recommended target areas for policy options and interventions.
- Action 4.** Develop the global country support network of experts and strengthen global coordination of relevant activities of the WHO collaborating centres in order to increase the Secretariat's capacity to respond to Member States' requests for support of their efforts to develop, implement and evaluate strategies and programmes to reduce the harmful use of alcohol.
- Action 5.** Develop a global programme of training activities on priority areas for global action and target areas for action at national level, and implement this programme by organizing and supporting global, regional and intercountry workshops, seminars (including web-based seminars), online consultations and other capacity-building activities.
- Action 6.** Support and conduct capacity-building projects and activities on planning and implementing research and dissemination of research findings with a particular focus on alcohol policy research in low- and middle-income countries, and data generation to produce reliable estimates of [harmful use of alcohol](#), alcohol consumption, alcohol-related harm and treatment coverage for alcohol use disorders.
- Action 7.** Reconvene the WHO Expert Committee on Problems Related to Alcohol Consumption for a comprehensive review of the accumulated evidence on feasible and effective measures to address the harmful use of alcohol, and provide recommendations on the way forward to strengthen implementation of the Global Strategy.

Proposed actions for international partners and non-State actors

- Action 1.** Major partners within the UN system and intergovernmental organizations are invited to prioritize technical assistance and capacity-building activities for accelerating implementation of the Global Strategy in their developmental assistance and country support activities and plans.
- Action 2.** Civil society organizations, professional associations and research institutions are invited to develop capacity-building activities at national and, if appropriate, international levels within their roles and mandates. They are invited to contribute to capacity-building and provide technical assistance activities undertaken by Member States, WHO or other international organizations in line with the objectives and principles of the Global Strategy.
- Action 3.** Economic operators in alcohol production and trade are invited to implement capacity-building activities within their sectors of alcohol production, distribution and sales, and refrain from engagement in capacity-building activities outside their core roles that may compete with the activities of the public health community.

ACTION AREA 5: KNOWLEDGE PRODUCTION AND INFORMATION SYSTEMS

Production and dissemination of knowledge facilitates advocacy, policy prioritization and evaluation, and supports overall global actions to reduce the harmful use of alcohol. International collaborative research and knowledge production should focus on the generation of data that are

highly relevant to the development and implementation of alcohol policies. Effective monitoring of levels and patterns of alcohol consumption in populations and of alcohol-related harm, including alcohol-attributable disease burden, is of utmost importance for monitoring progress of implementation of the Global Strategy at national, regional and global levels, and should be conducted in conjunction with monitoring implementation of alcohol policy measures. Effective monitoring of alcohol consumption, alcohol-related harm and policy responses requires streamlined data generation, collection, validation and reporting procedures that will allow regular updates of country-level data at 1–2-year intervals with minimized time lags between data collection and reporting. Effective monitoring of treatment coverage for alcohol use disorders not only requires these actions but better methods of monitoring treatment coverage, all within the framework of universal health coverage.

Significantly more resources are required for investment in international research on alcohol policy development and implementation in low- and middle-income countries, on the reasons for uneven implementation of alcohol policy measures in different jurisdictions, with quantitative and qualitative analyses of barriers, enabling factors and the impact of different policy options, as well as in different population groups.

Research, including international research projects, is needed on the role of [harmful use of alcohol consumption](#) in the transmission, progression and treatment outcomes of some infectious diseases, on harm to others from drinking, on the impact of the harmful use of alcohol on child development and maternal health, as well as on the consumption of informally and illegally produced alcohol and its health consequences. International studies are needed on effective ways to increase the health literacy of people who consume alcohol. Studies on the costs and benefits of alcohol control measures and development of investment cases can help to overcome resistance to effective alcohol control measures in view of financial and other revenues associated with alcohol production and trade.

Global targets for Action area 5

Global target 5.1: By 2030, 75% of countries have data generated and regularly reported at the national level on [the harmful use of alcohol](#), alcohol consumption, alcohol-related harm and implementation of alcohol control measures.

Global target 5.2: By 2030, 50% of countries have a core set of indicators and national data for monitoring progress on attainment of universal health coverage for alcohol use disorders and major health conditions due to alcohol use.

Proposed actions for Member States

- Action 1.** Support the generation, compilation and dissemination of knowledge on the magnitude and nature of public health problems caused by the harmful use of alcohol and effectiveness of different policy options, and undertake activities for informing the general public about health risks associated with alcohol consumption.
- Action 2.** In coordination with relevant stakeholders, develop or strengthen national monitoring systems for monitoring [the harmful use of alcohol](#), alcohol consumption, its health and social consequences, and respective policy responses, in line with the SDGs and WHO indicators and their definitions.
- Action 3.** Establish national monitoring centres or other appropriate institutional entities with responsibility for collecting and compiling national data on [the harmful use of alcohol](#), alcohol consumption, alcohol-related harm and policy responses, as well as monitoring trends and reporting regularly to WHO's regional and global information systems on alcohol and health.
- Action 4.** Include alcohol modules in data collection tools used in population-based surveillance activities at national and subnational levels to facilitate international comparisons.
- Action 5.** Collaborate with the WHO Secretariat on global surveys on alcohol and health by collecting, collating, validating and reporting the required information, and including relevant questions on [the harmful use of alcohol](#), alcohol consumption and alcohol-related harm in national surveillance tools and activities.

- Action 6.** Document, collate and disseminate practical experiences with the implementation of alcohol policy measures and interventions, and support and promote evaluation of their effectiveness, cost-effectiveness and impact on alcohol-attributable harm in order to document feasibility, effectiveness and cost-effectiveness of policy measures in different contexts.

Actions for the Secretariat

- Action 1.** Maintain and further develop the WHO Global Information System on Alcohol and Health (GISAH) and regional information systems by developing and integrating indicators for monitoring implementation of the Global Strategy, further operationalization and standardization of GISAH indicators, coordination of data collection activities at all levels, and bringing together information on the effectiveness and cost-effectiveness of policy measures and interventions to reduce the harmful use of alcohol and public health problems attributable to alcohol.
- Action 2.** Support capacity-building for research, monitoring and surveillance on alcohol and health by establishing and supporting global and regional research networks, training and supporting data collection, analysis and dissemination.
- Action 3.** Prepare and implement during the period 2022-2030 at least three waves of data collection on [the harmful use of alcohol](#), alcohol consumption, alcohol-related harm and alcohol policies from Member States through the WHO Global Survey on Alcohol and Health (tentatively in 2022, 2025 and 2028) and from other relevant information sources. Also, use computerized data collection tools and web-based data collection platforms, and disseminate information through GISAH, regional information systems and global and regional status reports on alcohol and health. Whenever necessary, organize data consensus workshops for improving the quality of data.
- Action 4.** Constantly review, analyse and disseminate emerging scientific evidence on the magnitude and nature of public health problems attributable to [the harmful use of alcohol consumption](#) as well as on the effectiveness and cost-effectiveness of policy measures and interventions. This includes meetings of the technical advisory group on alcohol and drug epidemiology.
- Action 5.** Continue to generate comparable data on [the harmful use of alcohol](#), alcohol consumption, alcohol-related mortality and morbidity, and estimates of alcohol-attributable burden within the comparative risk assessment and global burden of disease estimates.
- Action 6.** Continue and further develop collaboration with international and United Nations agencies on data collection and analysis as well as continue dialogue and information exchange with alcohol producers and industry-supported research groups and organizations to improve the coverage and quality of data on alcohol consumption and availability of alcoholic beverages at global, regional and national levels.
- Action 7.** Promote and support priority setting for international research on alcohol and health as well as specific international research projects in low- and middle- income countries with a particular focus on the epidemiology of [the harmful use of alcohol](#), alcohol consumption and alcohol-related harm, evaluation of policy measures and interventions in health services, comparative effectiveness research, and the relationship between harmful use of alcohol and social and health inequities. Initiate and implement in selected low- and middle-income countries international research projects on harm to other than drinkers, including research on fetal alcohol spectrum disorders.
- Action 8.** Develop methodology, core indicators, computerized data collection tools and support generation of comparable data on implementation of effective policy measures at national level using the system of indices and scores, and support information and experience sharing among countries, particularly with similar socio-economic and cultural contexts.

Proposed actions for international partners and non-State actors

- Action 1.** Major partners within the United Nations system and intergovernmental organizations are invited to support knowledge generation and monitoring activities on alcohol and health at all levels, including alcohol policy research, to work with WHO on harmonization of indicators and data collection tools, and to support national monitoring capacities in line with reporting commitments for the major international monitoring frameworks.
- Action 2.** Civil society organizations, professional associations and research institutions are invited to support WHO efforts on data collection and analysis to improve the coverage and quality of data on [the harmful use of alcohol](#), alcohol consumption, alcohol-related harm, policy responses and treatment coverage for alcohol use disorders at global, regional and national levels, and to support countries in their efforts to build and strengthen research and monitoring capacities in this area.
- Action 3.** Economic operators in alcohol production and trade are invited to disclose, with due regard of limitations associated with confidentiality of commercial information, data of public health relevance that can contribute to improvement of WHO estimates of alcohol consumption in populations, such as data on production and sales of alcoholic beverages and data on consumer knowledge, attitudes and preferences regarding alcoholic beverages.

ACTION AREA 6: RESOURCE MOBILIZATION

Lack of resources presents a primary barrier to introducing or accelerating global and national actions to reduce the harmful use of alcohol. Adequate resources need to be mobilized at all levels for implementation of the Global Strategy, namely for: 1) development, implementation and monitoring of alcohol policies in low- and middle-income countries; 2) international collaboration and research in this area; and 3) civil society engagement at the international level to reduce harmful use of alcohol. Such resources are not limited to funding, although this is a priority, but also include human resources and workforce capacity, appropriate infrastructures, international cooperation and partnerships.

The lack of resources to finance alcohol control measures, as well as programmes and interventions for prevention and treatment of substance use disorders, requires innovative funding mechanisms if the related targets of the Sustainable Development Goals are to be met. Several innovative approaches that combine evidence-based knowledge with more unorthodox ideas have been reported across countries and at the international level. There are existing examples of revenues from taxes on alcoholic beverages being used to fund health-promotion initiatives, health coverage of vulnerable populations, prevention and treatment of alcohol and substance use disorders and, in some cases, support to international work in these areas. In some jurisdictions, earmarked funding for the prevention and treatment of alcohol use disorders and related conditions is provided with funds generated from state-owned retail monopolies, a levy on profits across the value chains for alcoholic beverages, taxing alcohol advertising, or fines for noncompliance with alcohol regulations. [Consideration should be given to an intergovernmental commitment to a global tax on alcohol to support this effort, with the use of the money raised to be governed internationally.](#)

Global targets for Action area 6

Global target 6.1: 50% of countries⁸ have increased available resources for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.

Global target 6.2: An increased number of countries with earmarked funding from alcohol tax revenues for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.

Proposed actions for Member States

- Action 1.** Increase allocation of resources, including international and domestic financial resources generated by new or innovative ways and means to secure essential funding, for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions according to the scope and nature of public health problems caused by harmful use of alcohol.
- Action 2.** Consider the development and implementation of earmarked funding or contributions from alcohol tax revenues or other revenues linked to alcohol beverage production and trade for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.
- Action 3.** Increase the resources available for implementation of the Global Strategy and action plan by mainstreaming alcohol policy options and interventions in public health and developmental activities

⁸ The baseline for this indicator is the year of endorsement of the action plan.

in other areas such as maternal and child health, violence prevention, road safety and infectious diseases.

- Action 4.** Participate in and support international collaboration to increase resources available for accelerating implementation of the Global Strategy and action plan to reduce the harmful use of alcohol and support provided to low- and middle-income countries in developing and implementing high-impact strategies and interventions.
- Action 5.** Promote and support resource mobilization for implementation of the Global Strategy and action plan to reduce the harmful use of alcohol in the framework of broad developmental agendas such as the 2030 Agenda for Sustainable Development and responses to health emergencies such as the COVID-19 pandemic.
- Action 6.** Share experiences at the international level, including with the WHO Secretariat and other international organizations, of good practice in financing policies and interventions to reduce the harmful use of alcohol.

Actions for the Secretariat

- Action 1.** Collect, analyse and disseminate experiences and good practices in financing policies and interventions to reduce harmful use of alcohol and implement new or innovative ways and means to secure adequate funding for implementation of the Global Strategy at all levels.
- Action 2.** Develop and disseminate technical tools and information products in support of efforts to increase the resources available for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.
- Action 3.** At global and regional levels, monitor allocation of resources for the implementation of the Global Strategy and action plan.
- Action 4.** Promote and support pooling of resources and their effective use by better coordination and intensified collaboration between different programme areas within WHO, United Nations agencies and other international partners.
- Action 5.** Promote allocation of resources for alcohol policy development and implementation of the Global Strategy and action plan in bilateral and other cooperation agreements with donor countries and agencies.
- Action 6.** Intensify fundraising efforts to support implementation of the Global Strategy in low- and middle- income countries by organizing donor conferences and meetings of interested parties.

Proposed actions for international partners and non-State actors

- Action 1.** Major partners within the United Nations system and intergovernmental organizations are invited to mainstream their efforts to reduce the harmful use of alcohol in their developmental and public health strategies and action plans and to promote and support financing policies and interventions to ensure the availability of adequate resources for accelerated implementation of the Global Strategy while maintaining independence from funding from alcohol producers and distributors.
- Action 2.** Civil society organizations, professional associations and research institutions are invited to promote and support new or innovative ways and means to secure required funding and to facilitate collaboration of the finance and health sectors to ensure mobilization, allocation and accountability of the resources necessary to reduce the harmful use of alcohol and accelerate implementation of the Global Strategy at all levels.
- Action 3.** Economic operators in alcohol production and trade are invited to allocate resources for implementation of measures that can contribute to reducing the harmful use of alcohol within their core roles, and to ~~avoid exerting any undue influence, refrain from when direct~~ funding of public health and policy-related research to prevent any potential bias ~~in agenda-setting~~ emerging from the conflict of interest, ~~and cease sponsorship of scientific research for marketing or lobbying purposes.~~

ANNEX 1: INDICATORS AND MILESTONES FOR ACHIEVING GLOBAL TARGETS

Global targets	Indicators	Milestones	Comments
1.1. 75% of countries have strengthened and sustainably enforced implementation of high-impact policy options and interventions.	Composite indicator for monitoring implementation of high-impact policy options and interventions (to be developed).	2019 2022 2023 2025 2028/9	Data collected through WHO global survey on alcohol and health, SAFER monitoring and other relevant activities undertaken at the global and regional levels.
1.2. At least x% relative reduction in the harmful use of alcohol per capita (15 years and older) consumption achieved by 2025 and x% relative reduction by 2030. ⁹	Harmful use of alcohol (including indicators such as heavy episodic drinking, alcohol-attributable DALYs and alcohol-attributable death rates) and Total alcohol per capita consumption defined as the total (recorded plus estimated unrecorded alcohol) alcohol per capita (aged 15 years and older) consumption within a calendar year in litres of pure alcohol, adjusted for tourist consumption.	2010 2016 2019 2022 2023 2024 2028 2030	Annual WHO estimates produced on the basis of data submitted by Member States and generated through WHO global and regional monitoring and surveillance activities.
1.3. By 2030, 80% of the world population are protected from the harmful use of alcohol by sustained implementation and enforcement of high-impact policy options with due consideration of national contexts, priorities and available resources.	The size of the world population (as a percentage of the world population) living in countries which have enacted and enforced effective and cost-effective strategies and interventions to reduce the harmful use of alcohol. Full operationalization of the indicator to be developed.	2016 2019 2022 2023 2025 2028/9	Data collected through WHO global survey on alcohol and health, SAFER monitoring and other relevant activities undertaken at the global and regional levels.

⁹ The target figures for this indicator are to be defined on the basis of analysis of the WHO data on alcohol consumption.

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2.1: By 2030, 75% of countries have developed and enacted a written national alcohol policy that is based on best available evidence and supported by legislative measures for effective implementation of high-impact strategies and interventions.	Number of countries (as a percentage of all WHO Member States) with a written and enacted national alcohol policy, supported by required legislative measures.	2019 2022 2025 2028/9	Data collected through WHO global survey on alcohol and health and the WHO NCD country capacity survey.
2.2: By 2030, 50% of countries produce periodic national reports on the harmful use of alcohol , alcohol consumption, alcohol-related harm and effective policy responses targeting decision-makers and the general public.	Number of countries (as a percentage of all WHO Member States) producing at least two national reports within the last 8-year period on the harmful use of alcohol , alcohol consumption, alcohol-related harm and written national alcohol policy, including legislative measures.	2022 2025 2028/9	Data collected through WHO global survey on alcohol and health, SAFER monitoring and other relevant activities undertaken at the global and regional levels.
3.1: x% ¹⁰ of countries have established and functioning national and subnational multisectoral partnerships for implementation of effective alcohol control measures.	Number of countries (as a proportion of all WHO Member States) with established and multisectoral partnerships for implementation of effective alcohol control measures (including the number of countries implementing the SAFER initiative). Full operationalization of the indicator to be developed.	2022 2025 2028/9	Data collected through WHO global survey on alcohol and health, SAFER monitoring and other relevant activities undertaken at the global and regional levels.

¹⁰ The figure is to be defined on the basis of reanalysis of data from the relevant WHO surveys.

<p>3.2: 75% of countries are engaged in the work of the global and regional networks of WHO national counterparts for international dialogue and coordination on reducing the harmful use of alcohol.</p>	<p>Number of countries (as a proportion of all WHO Member States) actively represented in the global and regional networks of WHO national counterparts.</p>	<p>2021 2022 2023 2024 2025 2026 2027 2028 2029 2030</p>	<p>Information from WHO regional offices and Headquarters collated on the annual basis.</p>
<p>4.1: 50% of countries have increased capacity and infrastructure for implementation of high-impact strategies and interventions to reduce the harmful use of alcohol.</p>	<p>Number of countries (as a proportion of all WHO Member States) that have increased capacity and infrastructure for implementation of high-impact strategies and interventions to reduce the harmful use of alcohol (including the number of countries implementing the SAFER initiative). Composite indicator with operationalization to be developed.</p> <p>The baseline for this indicator is the year of endorsement of the action plan.</p>	<p>2022 2025 2028/9</p>	<p>Data collected through WHO global survey on alcohol and health, SAFER monitoring and other relevant activities undertaken at the global and regional levels.</p> <p>The figure is indicative and subject to adjustment after reanalysis of data from the relevant WHO surveys.</p>
<p>4.2: 50% of countries have increased capacity to provide prevention and treatment interventions for health conditions due to the harmful use of alcohol use in line with the principles of universal health coverage.</p>	<p>Number of countries (as a proportion of all WHO Member States) that have increased capacity to provide prevention and treatment interventions for health conditions due to alcohol use in line with the principles of universal health coverage. The work on this indicator as a proxy measure for treatment coverage for alcohol use disorders and related health conditions is currently in progress.</p> <p>The baseline for this indicator is the year of</p>	<p>2019 2022 2025 2028/9</p>	<p>Data collected through WHO global survey on progress towards attainment of SDG health target 3.5 on prevention and treatment of substance abuse.</p> <p>This figure is indicative and subject to adjustment after reanalysis of data from the relevant WHO surveys.</p>

	endorsement of the action plan.		
5.1: By 2030, 75% of countries have data generated and regularly reported at the national level on levels and patterns of the harmful use of alcohol , alcohol consumption, alcohol-related harm and implementation of alcohol control measures.	Number of countries (as a proportion of all WHO Member States) that generate and report national data on the harmful use of alcohol , per capita alcohol consumption, alcohol-related harm and policy responses.	2019 2022 2025 2028/9	Passive literature surveillance and data collected through WHO global surveys on alcohol and health and progress with attainment of SDG health target 3.5; data collected through activities undertaken for SDG 3.5.2 monitoring.
5.2: By 2030, 50% of countries have a core set of indicators and national data generated at national level for monitoring progress with attainment of universal health coverage for alcohol use disorders and major health conditions due to alcohol use.	Number of countries (as a proportion of all WHO Member States) that have a core set of agreed indicators and generate and report national data on treatment coverage and treatment capacity for alcohol use disorders and related health conditions, alcohol-related harm and policy responses.	2019 2022 2025 2028/9	Passive literature surveillance and data collected through WHO global survey on progress towards attainment of SDG health target 3.5; data collected through activities undertaken for SDG 3.5.1 monitoring.
6.1: 50% of countries have increased or ensured appropriate levels of available resources for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.	Number of countries (as a proportion of all Member States) that have increased or ensured appropriate levels of available resources to finance alcohol control measures and interventions for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions. The baseline for this indicator is the year of endorsement of the action plan.	2022 2025 2028/9	Data collected through WHO global survey on alcohol and health, SAFER monitoring and other relevant activities undertaken at the global and regional levels.

6.2: An increased number of countries with earmarked funding from alcohol tax revenues for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.	Number (absolute) of countries that have introduced earmarked funding from alcohol tax revenues for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.	2022 2025 2028/9	Data collected through WHO global surveys on alcohol and health and progress towards attainment of SDG health target 3.5; data collected through activities undertaken for SDG 3.5.1.
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DRAFT

ANNEX 2: WHO EXECUTIVE BOARD DECISION EB146(14)

EXECUTIVE BOARD
146th session

EB146(14)
7 February 2020

Agenda item 7.2

Accelerating action to reduce the harmful use of alcohol

The Executive Board, having considered the report on the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases,¹ particularly Annex 3, entitled "Implementation of the global strategy to reduce the harmful use of alcohol," and the report on the findings of the consultative process on implementation of the global strategy to reduce the harmful use of alcohol and the way forward;²

Noting with grave concern that, globally, the harmful use of alcohol causes approximately 3 million deaths every year; and that, despite the reduction of age-standardized alcohol-attributable deaths and disability-adjusted life years and of heavy episodic drinking, the overall burden of disease and injuries attributable to alcohol consumption remains unacceptably high; and emphasizing that there is sufficient evidence for the carcinogenicity of alcohol and a causal contribution of the use of alcohol to the development of several types of cancers in humans;³

Recognizing the continued relevance of the global strategy to reduce the harmful use of alcohol and further recognizing that resources and capacities for its implementation in WHO and some Member States do not correspond to the magnitude of the problems;

Expressing deep concern that alcohol marketing, advertising and promotional activity, including through cross-border marketing, targeting youth and adolescents, influences their drinking initiation and intensity of drinking;³

Noting that some WHO offices do not offer alcohol as a practice to accelerate action to reduce the harmful use of alcohol.

Decided to request the Director-General:

(1) to develop an action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority, in consultation with Member States and relevant stakeholders, for consideration by the Seventy-fifth World Health Assembly, through the Executive Board at its 150th session in 2022;

¹ Document EB146/7.

² Document EB146/7 Add.1.

³ Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1>, accessed 7 February 2020).

(2) to develop a technical report on the harmful use of alcohol related to cross-border alcohol marketing, advertising and promotional activities, including those targeting youth and adolescents, before the 150th session of the Executive Board, which could contribute to the development of the action plan;

(3) to adequately resource the work on the harmful use of alcohol;

(4) to review the global strategy to reduce the harmful use of alcohol and report to the Executive Board at its 166th session in 2030 for further action.

Twelfth meeting, 7 February 2020
EB146/SR/12

DRAFT

Chamber of Agricultural and Food Enterprises, Chamber of Commerce and Industry Slovenia

Department/Unit: *Association of Slovene Brewers*

Country/Location: Slovenia

Submission

Yes,

we have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration.

Attachment(s): 1

00281_54_asb-cafi-slovenia-support-comments-submission-to-the-gsap-online-consultation.pdf

WHO working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Association of Slovene Brewers's support, comments and suggestions for consideration 7 December 2020

Subject: Submission to the Global strategy to reduce the harmful use of alcohol (GSAP) Online Consultation

We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration.

Association of Slovene brewers, part of the Chamber of Agricultural and Food Enterprises, Chamber of Commerce and Industry Slovenia

Association of Slovene brewers based in Ljubljana, is a representative of Slovene brewers. We cover middle sized-global brewers and craft and pub brewers in Slovenia. The main pillars of work are promoting and developing an advanced business environment for the brewing sector, we care and act to transfer of knowledge and good practices between brewers and related organizations and the integration of domestic beer makers with the international environment, through our action, we are reducing the impact of our action on the environment and raising efficiency, encouraging synergies between brewing, agriculture and the natural environment, improving brewing practices, advocating the creation of sustainable regulation: traceability from grain (hops) to glass.

We would like to be an active partner in formulating the alcohol policy and advocacy for moderate and responsible beer consumption especially regarding the drink and drive initiatives and help to prevent the binge drinking, heavy episodic drinking, focusing on responsible consumption of beer in regards to the underage drinking and adolescent binge drinking, to be a support for all health advices to the consumers.

We have been proud member of The Brewers of Europe for many years and we strongly support the initiatives and opinion made from the side of Brewers of Europe to the GASP as follows.

Data on consumption trends between 2010 and 2018

With specific attention to our Europe-wide remit, it is critical to note that not only has alcohol consumption declined in the Europe region but so has alcohol-related harm in the period 2010-2018. It is important to base policies not solely on overall alcohol consumption but also more granular indicators, including around specific beverages:

- In the European Union, not only did alcohol consumption decline but so have key harm indicators such as heavy episodic drinking, drink driving accidents and fatalities. The recently published 2019 ESPAD report, building on the previous report and the HBSC reports, also show significant declines in both underage drinking and adolescent binge drinking. In Slovenia we can see the significantly decreasing trend in lifetime use of alcohol and heavy episodic drinking in the period 1995-2019 (ESPAD 2019).
- All these declines have actually taken place within a context where beer consumption has increased by 4% between 2010 and 2018.

- These data demonstrate how increased consumption of low alcohol beverages such as beer, in sectors such as brewing where there is also a growth in lower and non-alcohol versions, can actually result in improved health outcomes, as consumers switch from higher alcohol products.

The role for lower alcohol beverages

All European countries, in one manner/policy or another, treat different alcoholic beverages differently, whether it be through the fiscal system, the rules on access to alcohol or the places and times where marketing is permitted. The Working Document is a missed opportunity to reflect this reality and act on the evidence that alcohol policies in the areas of taxation, availability, and marketing can be adjusted to nudge consumers toward lower-alcohol-strength beverages, significantly reducing alcohol-related harms. The evidence shows that:

- The effects of alcohol consumption depend on what you drink and how you drink it. Rapid consumption of highly concentrated alcohol, for example, carries a higher risk for certain harms.
- Using policy levers to nudge consumers toward lower-alcohol-strength products can significantly reduce alcohol-related harm while also creating incentives for producers to create lower-alcohol-strength products.
- Numerous alcohol policy experts have called for more widespread implementation of this approach.

In Slovenia non-alcoholic beer has more and more consumers. The real role of the brewers seems to be how to show consumers that non-alcoholic beer is a healthy choice not only in case of driving but also as every day possible choice instead of any other alcoholic drink.

Where business and public health interests meet

The Working Document also argues that there is an inherent conflict between the interests of alcoholic drinks producers and the interests of public health. This presumed conflict is used to justify excluding all drinks sectors from all discussions on public health policy. However, there is no inherent conflict of interest between the brewers' interests and those of public health, and no justification to de facto exclude brewers from all public policy discussions.

The brewing sector is highly local, and the success of the business depends on the socio-economic health of the communities where brewers operate. Brewers also have important insights that are important to the decision-making of governments and support the "whole of society" approach championed by the WHO and its leadership:

- The Brewers of Europe has for example committed, in the absence of a legal obligation set in EU law, to voluntarily roll out ingredients and calorie labelling across the continent.
 - The brewing sector is voluntarily doing so in exactly the same manner in which non-alcoholic beverages and foods are legally obliged to do so.
 - The ambition is to ensure that all pre-packed beer containers carry this information in 2022, with interim targets being met thus far.
- Brewers have also invested heavily in the development and adoption of low- and no-alcohol beers and policies that accelerate consumer adoption remain key to expanding their availability.
 - These innovations are responsive to consumer demand for lower alcohol products, offering responsible consumer choice in situations where alcohol consumption is either inadvisable (for example when driving, pregnant etc.) or when a consumer simply wishes to consume beer but also to consume less or no alcohol.
 - Non- and low- alcohol innovations are consistent with the call in the Global Strategy for producers to "consider effective ways to prevent and reduce harmful use of alcohol within their core roles."
- Collaboration is critical for creating "win-win" situations like the beer sector's leadership on labelling and the expansion of low- and no-alcohol products. Reflecting on the potential of the brewers' ability to reduce alcohol content without changing the quality of beer, Professor Jurgen Rehm found that

¹ Rehm, Jürgen, et al. "Evidence of reducing ethanol content in beverages to reduce harmful use of alcohol." *The Lancet Gastroenterology & Hepatology* 1.1 (2016): 78-83.

“reduction of alcoholic strength might constitute a unique situation, whereby the interests of public health (in reducing overall consumption of alcohol) and the alcohol industry (in achieving profit) coincide.”¹

Beer disproportionately impacted by the COVID crisis

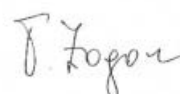
Finally, the current COVID-19 crisis has also constituted an interesting experiment into the impact of certain alcohol policies, showing that legislation has the potential to impact in different ways the consumption of different alcoholic beverages:

- In Europe, contrary to many anecdotal observations, the crisis has not led to increase per capita beer consumption, which has been specifically and particularly impacted by the closures of the hospitality sector.
- Beer is typically consumed in social settings and the full or partial closure of these regulated bar and restaurant environments, combined with further restrictions on social interactions in other, also private settings, has meant that the drops in hospitality beer sales (usually one third of the EU beer market) have not been matched at all by equivalent increases in beer sales from the retail sector.
- The EU beer market is forecast to have declined by up to 20% in 2020, meaning a major drop in the consumption of lower alcohol beverages, due entirely to the closure of the hospitality sector. In Slovenia the decline for brewers is up to 40% on the yearly level.
- Where home consumption has increased for some alcohol dependents, isolated at home without the usual support networks available, this demonstrates the need for targeted support for vulnerable populations.
- Supporting the recovery of the hospitality sector as a safe and regulated environment will support the nudging of consumers towards lower alcohol beverages.

As stated, we strongly support and share the opinion and vision of our European colleagues, members of The Brewers of Europe and in this way wishing to be an important part in the common goal to help reduce the harmful use of alcohol.



Alenka Lesjak
Secretary general
Association of Slovene Brewers,
GZS-ZKŽŠ



dr. Tatjana Zagorc
Director GZS-ZKŽP

8.December 2020

¹ Rehm, Jürgen, et al. "Evidence of reducing ethanol content in beverages to reduce harmful use of alcohol." *The Lancet Gastroenterology & Hepatology* 1.1 (2016): 78-83.

CHU de La Réunion

Department/Unit: *CESM - Pôle de Santé Mentale*

Country/Location: France

URL: <https://www.chu-reunion.fr/>

Submission

We advocate for recognition of a harmful use of alcohol starting from early adolescence on Reunion Island especially for adolescence with mental disorders or within local foster care institutions.

Attachment(s): 0

Civil Development Forum

Country/Location: Poland

URL: www.for.org.pl

Submission

The plan for the Global Strategy signals radicalisation of the World Health Organization approach towards the use of alcohol. Despite its title and emphasis on “harmful use” it promotes policies that will further restrict freedom of choice of individuals and personal responsibility connected with these choices. The Action Areas will require to devote even more public resources, i.e. taxpayers money, on alcohol policies based on narrow cost-benefit analysis. The international approach proposed by the WHO towards local problems that may appear due to misuse of alcohol are inappropriate regarding different local cultures and conditions. Problems related to alcohol policies, like illicit alcohol production and trade, are not taken into consideration and proposed solutions can only increase the size of shadow economies in many countries. Promotion of even more anti-alcohol activism may also lead to waste of scarce public resources while there are other health priorities at the national and global levels.

See the attached document for more detailed comments.

Attachment(s): 1

00461_87_for-response-to-global-strategy-by-who-2020.pdf

Warsaw, 12 December 2020

Civil Development Forum's response to consultation on a working document for development of an action plan to strengthen implementation of the "Global Strategy to Reduce the Harmful Use of Alcohol"

Introduction

The plan for the Global Strategy¹ signals radicalisation of the World Health Organization approach towards the use of alcohol. Despite its title and emphasis on "harmful use" it promotes policies that will further restrict freedom of choice of individuals and personal responsibility connected with these choices. The Action Areas will require to devote even more public resources, i.e. taxpayers money, on alcohol policies based on narrow cost-benefit analysis. The international approach proposed by the WHO towards local problems that may appear due to misuse of alcohol are inappropriate regarding different local cultures and conditions. Problems related to alcohol policies, like illicit alcohol production and trade, are not taken into consideration and proposed solutions can only increase the size of shadow economies in many countries. Promotion of even more anti-alcohol activism may also lead to waste of scarce public resources while there are other health priorities at the national and global levels.

Cost-benefit analysis of alcohol policies

The Global Strategy emphasizes several times the „cost-effective alcohol policies”, including tax increases and various prohibitionist measures. Nevertheless, the WHO does not provide in the working document a formula for this cost-benefit analysis and it seems that many costs and benefits are ignored.

Alcohol production is an important part of many economies contributing to GDP growth, tax revenues and employment. Only spirit drinks generate 1 million direct jobs in production and

¹ World Health Organisation (2020) *Working document for development of an action plan to strengthen implementation of the "Global Strategy to Reduce the Harmful Use of Alcohol"*.

sales² and beer is a source of over 2 million jobs in production, retail and hospitality³ in the European Union.

The COVID-19 pandemic has shown well dependencies between many economic sectors – closing one branch of the economy due to virus-related restrictions affects many other, interconnected branches. Higher taxes and restrictions proposed by the WHO, apart from generating costs of consumers, will first affect entrepreneurs and employees of the alcohol production and sales and later do harm to other parts of the economy e.g. shopkeepers (including small, local shops), bars and restaurants, advertising, media, sports and many more. Moreover, prohibitionist measures generate costs or lost benefits for consumers that are difficult to calculate like pleasure related to alcohol consumption and social interactions related to alcohol or cost of time and effort related to purchases of alcohol when it is possible only to buy it in selected sales points, days or hours, with a need of unnecessary travel and planning. The freedom of choice lost by adult individuals due to “enacting and enforcing restrictions on the physical availability of retailed alcohol” (p. 2) should also be taken into consideration, especially when the Global Strategy mentions some other “social losses” hard to calculate like “pain and suffering” (p. 3).

Internationalism versus local conditions

While WHO notices that “the drinking of alcoholic beverages is strongly embedded in the social norms and cultural traditions of many societies” (p. 4), it also proposes legally binding, international level instruments. Firstly, universalism in the area that is “strongly embedded” in many *different* “social norms and cultural traditions” is a wrong strategy that can lead to many unintended consequences, including harm to local business and employment or growth of shadow economy and use of alcohol from illicit sources, when international instruments will tend to ignore regional, national and sub-national conditions. Secondly, the attempts to build international instruments to tackle alcohol consumption might be unjustified interference in national policies, especially in democratic states, and violate the principle of subsidiarity i.e.

² https://ec.europa.eu/info/food-farming-fisheries/plants-and-plant-products/plant-products/spirits_en

³ https://brewersofeurope.org/site/brewers/index.php?doc_id=850

dealing with problems related to harm done by misuse and excessive use of alcohol where these problems occur – at the local level by local authorities, institutions and communities.

This universalism and ignorance for local situation is visible when the WHO mentions “global health equity” in connection with alcohol control measures. The health conditions in various societies are formed by many factors (from environmental to GDP per capita) and will always differ despite attempts to build some kind of “global health equity”. There is no justified reason to associate alcohol policies with this utopian vision while individuals’ health depends on so many factors.

Shadow economy

Although the Global Strategy notices illicit alcohol production this problem requires much deeper analysis that should be included in the strategy. The goal of “reducing the public health impact of illicit alcohol and informally produced alcohol” (p. 9) cannot be achieved while higher taxes and prohibitionist measures are proposed. For example, the research done in the Baltic states, Poland, Czech Republic and Sweden shows that the major reason why people decide to buy illicit goods and services is that their legal equivalents are too expensive.⁴ It means also that certain products, like alcohol, can be overtaxed. Moreover, the impact of taxation upon the shadow goods market, including alcohol, depends on the level of income and the affordability of goods. These conditions, that differ from country to country, should also be taken into consideration before any universal and international strategies are proposed and implemented. As “taxes and regulations are (...) the primary causes of the shadow economy”⁵ the Global Strategy should reconsider its recommendation to further restrict alcohol policies as growth of illicit alcohol production and sales may harm both health of consumers and economies.

Campaigns and awareness

In Action Area 2 WHO focuses on campaigning and building awareness. In the Global Strategy we can read that “awareness and acceptance of the overall negative impact of alcohol

⁴ LFMI (2018) *Shadow Economy: Understanding Drivers, Reducing Incentives*, <https://www.llri.lt/wp-content/uploads/2018/11/Shadow-Economy.-Understanding-Drivers-Reducing-Incentives.pdf>

⁵ LFMI (2019) *Reducing Shadow Economies From Drivers To Policies*, <https://en.llri.lt/wp-content/uploads/2019/09/Seseline-ekonomika-EN-internetui.pdf>

consumption on a population's health and safety is low among decision-makers and the general public" (WHO 2020, p. 4).

The need to tackle inadequate awareness of populations and politicians is not based on any strong evidence. We have witnessed significant activism of decision-makers in the field of alcohol regulations (so at least in the European Union it is hard to see where "general trends towards deregulation" and "weakening of alcohol controls", mentioned by the WHO, took place) in many countries for years.⁶ Even if true reasons were different (e.g. fiscal targets) the arguments related to health and negative impact of alcohol have been usually behind these policies. The comparative studies in the EU of attitudes towards alcohol also do not confirm low awareness of possible harm done by alcohol.⁷ The Eurobarometer study shows that awareness of risks associated with alcohol in the Eurobarometer study is high for liver disease (97% awareness), medium for heart disease or birth defects, and low for cancers – by "low" the authors mean 67% awareness. The same study also shows that vast majority of people is aware that consumption of alcohol may sometimes be behind selected social harms like violence or marital difficulties.

The study in the EU was done over 10 years ago but even the WHO claims that there has been "increasing awareness of negative health and social consequences of the harmful use of alcohol, and alcohol's causal relationships with some types of cancer, liver and cardiovascular diseases" (p. 5). It shows that more "activism" in the field of alcohol might not be needed and more public resources should not be spent on this goal. While there is nothing wrong in voluntary civil society actions for various causes, from promoting smaller or no consumption of alcohol to supporting freedom of choice for consumers, there is no need to devote even more taxpayers' money into campaigns inspired by documents like the Global Strategy.

Conclusions

The WHO declares that "the goal of the action plan is to boost effective implementation of the Global Strategy as a public health priority" but current COVID-19 pandemics show that there

⁶ See for example C. Snowdon (2019) *Nanny State Index* and previous editions available at: <http://nannystateindex.org/>

⁷ Eurobarometer 331, *EU citizens' attitudes towards alcohol*
https://data.europa.eu/euodp/en/data/dataset/S798_72_3_EBS331

are other, more important health priorities for public authorities and international institutions, including the WHO. Many recommendations in the Global Strategy ignore costs that are related to prohibitionist approach towards alcohol while they will generate even greater burden on consumers and national budgets

Author: Marek Tatała, Vice President, Economist, Civil Development Forum (Forum Obywatelskiego Rozwoju – FOR), a think tank from Poland (www.for.org.pl)

Contact details: marek.tatala@for.org.pl

Clinique Belmont Genève

Department/Unit: *Addictology*

Country/Location: France

Submission

On the ten actions, I would add pregnancy women. I think we should make a focus on women. It is not well known, but so important.

For brief interventions, it must be used as often as possible, and mainly with vulnerable populations.

Attachment(s): 0

COALICIÓN MÉXICO SALUD-HABLE

Department/Unit: *COORDINACIÓN*

Country/Location: Mexico

URL: <http://mexicosaludhable.org/>

Submission

Para fortalecer las restricciones a la disponibilidad de alcohol es necesario reducir la densidad de puntos de venta y que éstos no se ubiquen cerca de escuelas, que haya rigor en las sanciones a quienes expendan alcohol a menores de edad; sobre las medidas en contra de conducir vehículos y beber, que se reduzcan los horarios de venta y estén homologados en todos los municipios y estados de los países; que se homologuen los reglamentos de tránsito en municipios, estados y países, con un solo índice máximo de concentración de alcohol en la sangre, que se aumenten los puntos de revisión de alcoholemia, no solo en fines de semana y que se cancelen definitivamente las licencias de conducir a conductores reincidentes en usar alcohol mientras manejan; acerca del acceso a tamizaje, intervenciones breves y tratamiento a problemas por consumo de alcohol, que se capacite al personal del primer nivel de atención en salud para que imparta consejería breve de impacto para dejar de beber o para que las personas no comiencen a beber alcohol, poner a disposición programas permanentes de tratamiento y rehabilitación para bebedores y sus familiares, abrir espacios en hospitales generales para enfermos a causa del uso nocivo de alcohol, eliminar barreras sociales, económicas, culturales y administrativas que estigmatizan el consumo nocivo de alcohol, principalmente en las mujeres, desplegar campañas nacionales de sensibilización dirigidas a familias y personal de la educación para que inhiban o contengan el consumo de alcohol en niños y adolescentes, así como colaborar con los grupos de ayuda mutua de Alcohólicos Anónimos, que ayudan a las personas a mantenerse en sobriedad; sobre la prohibición de publicidad, promoción y patrocinio (ppyp) de bebidas alcohólicas, eliminar totalmente de los medios de comunicación escritos y audiovisuales, de las redes sociales (FB, TW, Instagram, etc.) cualquier forma de ppyp de alcohol, los obsequios de la industria alcoholera e invitaciones a espectáculos, rechazar cualquier intento de "autorregulación" de la industria alcoholera, evitar el conflicto de interés en funcionarios de gobierno, incluidos legisladores, jueces y magistrados para evitar su colusión con los promotores del uso de alcohol; sobre el incremento en los precios de las bebidas alcohólicas mediante el aumento de impuestos, promover la aplicación de impuestos especiales a la producción, distribución y comercialización de bebidas alcohólicas, nacionales o importadas y sin importar su graduación alcohólica, y aplicar dichos recursos fiscales a programas de prevención y control del consumo nocivo de alcohol, así como de atención a las enfermedades no transmisibles relacionadas con el consumo de productos etílicos

Attachment(s): 1

00202_22_reporte-de-la-sociedad-civil-sobre-consumo-nocivo-de-alcohol-1.pdf

COMISION PARA LA INDUSTRIA DE VINOS Y LICORES AC

Department/Unit: *SECRETARIADO TECNICO*

Country/Location: Mexico

Submission

Nos parece importante mencionar que el Documento de Trabajo en consulta se encuentra centrado en la aplicación de la estrategia SAFER y un marco regulatorio. En general, recomendamos atender la directriz de la Estrategia mundial para reducir el uso nocivo del alcohol, en cuanto a que se debe: “Tener en cuenta el «contexto» al recomendar medidas.

Si se limita a los países a evaluar el avance de la estrategia con base en la aplicación de las medidas contempladas unicamente en SAFER, se desechan muchas actividades y recursos que la industria ha estado aportando para la reducción del uso nocivo del alcohol.

En cuanto a la propuesta de que los gobiernos adopten el compromiso de establecer un impuesto global, nos parece importante comentar que el tema fiscal y en particular el establecimiento de los impuestos es una competencia absolutamente exclusiva de cada País y se debe respetar sus principios Constitucionales, su Soberanía y sus formas internas de organizarse. En todo caso con la recaudación actual de bebidas con alcohol

existe una gran oportunidad para que la inversión en prevención y reducción del uso nocivo del alcohol se pueda incrementar de manera importante.

Attachment(s): 1

00373_35_comentarios-civyl-a-consulta-oms-101220.pdf



CONSULTA EN LÍNEA SOBRE EL DOCUMENTO DE TRABAJO PARA EL DESARROLLO DE UN PLAN DE ACCIÓN GLOBAL PARA REDUCIR EL USO NOCIVO DEL ALCOHOL

Respecto a la Consulta sobre el Documento de Trabajo para el desarrollo de un Plan de acción global para Reducir El Uso Nocivo Del Alcohol, nuestros comentarios son los siguientes:

Nos parece importante mencionar que el Documento de Trabajo en consulta se encuentra centrado en la aplicación de la estrategia SAFER y un marco regulatorio en ese mismo sentido, lo cual deja de lado numerosos elementos contemplados en la Estrategia mundial para reducir el uso nocivo del alcohol, enfocándose así en acciones restrictivas como el aumento de impuestos o la limitación de la disponibilidad, lo que puede resultar contraproducente al no tener en cuenta las problemáticas de algunos países en particular, como es el caso de México y la lamentable existencia de un mercado ilícito que, de acuerdo a un estudio realizado por Euromonitor en 2018, se ubica en poco más del 36% en bebidas destiladas y teniendo como efecto riesgos sanitarios importantes que llegan hasta lamentables fallecimientos como los que recientemente afectaron a más de 200 personas; así como una pérdida fiscal anual de 8,500 millones de pesos mexicanos, que equivalen a poco más del 50% de la recaudación gubernamental, tan solo por concepto del impuesto especial que les aplica y, consecuentemente, el debilitamiento del Estado de Derecho.

En general, recomendamos atender la directriz de la Estrategia mundial para reducir el uso nocivo del alcohol, en cuanto a que se debe:

“Tener en cuenta el «contexto» al recomendar medidas. Gran parte de los datos publicados sobre la eficacia de las intervenciones de política relacionadas con el alcohol corresponden a países de ingresos altos, y se ha manifestado preocupación por el hecho de que la eficacia de esas intervenciones dependa del contexto y de que éstas puedan no ser reproducibles en otros entornos” (El subrayado se añadió)

Si se omite considerar el contexto específico de un País determinado, sea por sus particulares condiciones sociales, económicas, religiosas o políticas, se corre el riesgo fatal de tratar de implementar políticas públicas en materia de prevención del uso nocivo del alcohol que, pese a haber funcionado adecuadamente en otros Países, dadas las esenciales diferencias entre una y otra jurisdicción los efectos terminan siendo del todo distinto y, en muchas ocasiones, totalmente contraproducentes.

Otro tema que queremos destacar es que si se limita a los países a evaluar el avance de la estrategia con base en la aplicación de las medidas contempladas únicamente en SAFER, se desechan muchas actividades y recursos que la industria ha estado aportando para la reducción del uso nocivo del alcohol. Entre otras, el importante papel que está teniendo la industria en el marketing digital y el e-commerce mediante la autorregulación, entendida ésta como el establecimiento y cumplimiento de códigos de responsabilidad en la comercialización formales, o acuerdos informales para observar un comportamiento de productores, comercializadores, plataformas y servicios de cara al consumidor, que sea consistente con la prevención del uso nocivo del alcohol. Todo lo anterior en adición a lo que establece la normatividad y compartiendo las mejores prácticas para la protección de consumidores y de grupos vulnerables.

En cuanto a la propuesta de que los gobiernos adopten el compromiso de establecer un impuesto global con reglas internacionales para ser utilizado en el tratamiento de los trastornos por consumo de alcohol, nos parece importante comentar que el tema fiscal y en particular el establecimiento de los impuestos es una competencia absolutamente exclusiva de cada País y que se debe respetar sus principios Constitucionales, su Soberanía y sus formas internas de organizarse.

En todo caso, no por la vía de un impuesto pero sí de las contribuciones de cada Estado Miembro de la OMS y sección regional como es la OPS para el caso de México, ya existen los recursos para combatir el uso nocivo del alcohol; no para tratamientos pero sí en materia de prevención.

Además, cabe mencionar que durante el año 2019, en México se asignó un presupuesto de 1,284 millones de pesos mexicanos para prevenir y atender las adicciones, mientras que la recaudación total por el Impuesto Especial sobre Producción y Servicios a bebidas alcohólicas, cervezas y bebidas refrescantes fue de \$57,361.3 millones de pesos mexicanos; esto es, el 2.2% de lo recaudado, situación que es parecida a la de años anteriores, lo cual muestra que existe una gran oportunidad para que la inversión en prevención y reducción del uso nocivo del alcohol se pueda incrementar de manera importante.

Por todo lo anterior es que la Comisión para la Industria de Vinos y Licores (CIVyL) solicita reflexionar con mayor profundidad las medidas planteadas en el “Documento de trabajo para el desarrollo de un plan de acción global para reducir el uso nocivo del alcohol”, siempre teniendo en mente que las diferencias entre los distintos Estados Miembro son de tal forma grandes, que las medidas que han funcionado en algunos terminan siendo fatales en otros contextos, como antes se explicó.

Respetuosamente

José Ortiz
Secretario Técnico

Confederación Patronal de la República Mexicana (COPARMEX)

Department/Unit: *Asuntos Internacionales*

Country/Location: Mexico

URL: <https://coparmex.org.mx/>

Submission

- Existen importantes áreas de oportunidad para la mejora de la propuesta de documento presentada por la OMS, como, por ejemplo, el enfocarse en mecanismos comprensivos que incluyan a las aportaciones del sector privado como parte de la solución para mitigar el uso nocivo del alcohol. Los Objetivos de Desarrollo Sostenible (ODS) y las estrategias delineadas por la Organización Mundial de la Salud (OMS) hay un llamado enfático al sector privado para contribuir y participar en la implementación de soluciones para alcanzar dichos objetivos.
- Nuestros compromisos como sector privado en el tema tienen 5 ejes prioritarios: reducción del consumo de alcohol por menores de edad, fortalecimiento y expansión de los códigos de práctica de marketing, brindar información al consumidor e innovación responsable del producto, reducir el consumo de alcohol y conducir, solicitar el apoyo de los minoristas para reducir el consumo nocivo del alcohol.
- Consideramos que la mejor manera de alcanzar las metas de la ODS es desarrollando programas y políticas públicas enfocadas a bebedores nocivos.
- Se destacan y comparten algunos ejemplos de mejores prácticas en las que el sector empresarial ha contribuido para la adopción de políticas públicas y campañas para la reducción del consumo del alcohol.

Attachment(s): 1

00301_65_propuesta-coparmex-méxico-consulta-oms-sobre-consumo-alcohol.pdf

Committe for alcohol regulation - Brazil

Country/Location: Brazil

Submission

We would like to stress the need for support for raising awareness of alcohol problems in middle income countries, as in Brazil. My group has been trying almost alone to tackle this issue. I would be very happy if WHO could facilitate the implementation of civil society initiative, as ours.

Attachment(s): 0

Consejo Nacional Agropecuario, Asociación Civil

Department/Unit: *Vicepresidencia de Normalización*

Country/Location: Mexico

URL: www.cna.org.mx

Submission

CONSULTA PARA EL DESARROLLO DE UN PLAN DE ACCIÓN GLOBAL

PARA REDUCIR EL USO NOCIVO DEL ALCOHOL

En la High Level Meeting on Non Communicable Diseases, así como en la Estrategia mundial para reducir el uso nocivo del alcohol publicada en 2010 están claramente establecidos las acciones recomendadas, para que en el contexto de cada país se puedan enfrentar los desafíos de reducir el uso nocivo del alcohol; las cuales nos han servido en México para avanzar en ese objetivo, por lo que consideramos se debe respetar la vigencia y contenido de dicha Estrategia.

En particular queremos destacar la importancia del objetivo de “Posibilitar la acción intersectorial” y del enfoque social y que refieren dichos documentos, en los siguientes términos:

“La diversidad de los problemas asociados con el alcohol y de las medidas necesarias para reducir los daños relacionados con él apuntan a la necesidad de una acción integral en muchos sectores. Las políticas destinadas a reducir el uso nocivo del alcohol deben trascender el sector de la salud y hacer participar oportunamente a sectores como los del desarrollo, el transporte, la justicia, el bienestar social, la política fiscal, el comercio, la agricultura, la política sobre consumo, la educación y el empleo, así como a actores económicos y de la sociedad civil”.

“Los operadores económicos que intervienen en la producción y el comercio de alcohol son actores importantes en su calidad de desarrolladores, productores, distribuidores, comercializadores y vendedores de bebidas alcohólicas. Se los exhorta especialmente a que estudien medios eficaces de prevenir y reducir el uso nocivo del alcohol en el marco de sus funciones básicas antes mencionadas, incluidas las medidas e iniciativas de autorregulación. También podrían contribuir proporcionando datos sobre la venta y el consumo de bebidas alcohólicas.”

Es por lo anterior que se debe tener en cuenta que existe evidencia en muchos países, como es el caso de México, de que la colaboración social, incluyendo a los operadores económicos, es muy relevante, pues a través de sus conocimientos, programas y códigos es posible potenciar acciones que tengan por objetivo contar con prácticas responsables, desde el inicio de la cadena comercial, en distintos ámbitos y proteger a grupos vulnerables de influencias que pudieran ser negativas dada su condición. Tener un diálogo constante con la OMS mucho ayudaría a tener avances más significativos en los objetivos comunes para reducir el uso nocivo del alcohol, como es limitar el acceso de los menores de edad a las bebidas con alcohol.

Attachment(s): 0

Crisis Resolving Centre

Department/Unit: *Legal Aid*

Country/Location: United Republic of Tanzania

URL: www.crisisresolvingcener.wordpress.com

Submission

CRC would like to be added on the working team of an Action Plan.

Attachment(s): 1

00457_84_movendi-members-who-workingdoc-consultation.pdf



Submission - WHO Consultation - Working Document to develop an action plan for improving WHO GAS* implementation

CRISIS RESOLVING CENTRE (CRC) is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

CRC main mission is to advocate for women and children's rights by conducting awareness raising activities for cultural, policy and legal changes/transformation in the society. CRC has been undertaking legal Aid, Legal Education and Counseling Services for GBV survivors since its establishment including GBV related with Alcohol harmful.

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

- A. 7 Points for Action Plan Improvement
 1. Ensure bold targets and ambition
 2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
 3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
 4. Ensure greater focus on the SAFER strategies;
 5. Ensure greater focus on governance and infrastructure improvements;
 6. Improve resourcing as well as reporting and review of implementation; and
 7. Update nomenclature in line with state-of-the-art evidence.
- B. Additional point to be added to the action plan

1. Suggestion for elements of the action plan

C. Point of criticism and request for significant change

1. Role of the alcohol industry, conflict of interest

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol

policy-making initiatives encounter and have to overcome - and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as "complex" problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. "Complexity" arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change "the old" way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty - also to underpin the inclusion of "multisectoral action" as operating principle in the action plan.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world's children. The WHO-UNICEF-Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children's health, well-being and development - one of those being counter action against "predatory corporate behavior", including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to

facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets - the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions. Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be

summarized more effectively. They might be streamlined and prioritized.

Where possible, actions and key indicators should be time-bound.

4. Ensuring greater focus on the SAFER strategies

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions - to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol. We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys - that has largely fallen short of necessity - is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document. Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements - learning lessons from other health areas.

Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions - like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO - like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention - like there is for HIV/ AIDS, TB and Malaria.

4. There is no global initiative to advance alcohol taxation (or alcohol marketing) - like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm - like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm - like it was recently launched for AMR.
7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings - like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals - like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO's expert groups/ committees on alcohol - like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol - despite the existence of SDG 3.5 - to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

Regarding the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they

be included in the section of the action plan called "Infrastructure".

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential - as tobacco control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden. For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level. We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through "SAFER pilot countries".

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial - both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided. 'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets
2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.
3. Framework for action
 - Operational objectives: 8
 - Priority areas for global action: 6
 - Global action: WHO
 - National action: Member States
4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm. For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working

document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Dalgarno Institute

Department/Unit: *Education*

Country/Location: Australia

URL: www.dalgarnoinstitute.org.au

Submission

The attached concept paper content relates to drug policy for both licit and illicit drugs and as such applies to alcohol policy strategies

Attachment(s): 1

00514_32_drugpolicy-buildingordemolishingreslience-2020.pdf

Directorate of Health

Department/Unit: *Public Health*

Country/Location: Iceland

URL: www.landlaeknir.is

Submission

In our comments we address the terminology and to use harm done by alcohol, we address the industry and to advise those countries with strict policy not to give in to pressure and go towards less restrictive methods. Use SAFER as the only tool for implementation.

Attachment(s): 1

00206_26_who-consultation.pdf

WHO consultation – comments from Iceland.

Harmful use of alcohol – no safe limit is known for harmless use of alcohol so prefer to use the term harm done by alcohol or just consuming/consumption of alcohol. There is inconsistency in language when addressing alcohol and harm. Avoid inconsistency of terms, sometimes the wording is harmful use of alcohol and sometimes health risk of alcohol consumption...

Welcome the term and focus on “public health” in the document.

Avoid “false balance” when given the alcohol industry equal role as the industry have conflict of interest.

In countries with high age limit or restricted policy should be advised not to lower their restrictions or get less restrictive.

Distilled Spirits Council of the U.S.

Country/Location: United States of America

Submission

See attached.

Attachment(s): 1

00405_54_distilled-spirits-council-of-the-us.submission-for-who-global-strategy-working-document-consultation-12.12.2020.pdf

**Comments of the Distilled Spirits Council the United States (DISCUS)
on the “Working document for development of an action plan to strengthen
implementation of the Global Strategy to Reduce the Harmful Use of Alcohol”**

To be submitted online December 13, 2020

In response to: <https://www.who.int/publications/i/item/action-plan-to-strengthen-implementation-of-the-global-strategy-to-reduce-the-harmful-use-of-alcohol>

The Distilled Spirits Council of the United States (DISCUS) welcomes the opportunity to comment on the working document for development of an action plan to strengthen implementation of the World Health Organization’s (WHO) Global Strategy to Reduce the Harmful Use of Alcohol (“the Global Strategy”). DISCUS is a national trade association representing U.S. producers, marketers, importers and exporters of distilled spirits products.

At the outset, we reaffirm the U.S. spirits industry’s commitment to combating the harmful use of alcohol in all forms. We acknowledge that beverage alcohol products can be abused and result in harm. It is for these reasons that, throughout the decades, we have focused upon and pursued solutions that effectively address and combat the harmful use of alcohol. We fully support the public health objective of combating all forms of alcohol abuse and, for individuals of legal drinking age who choose to drink, encouraging moderate alcohol consumption. Some individuals of legal drinking age should not consume alcohol at all, and we support that decision.

I. Introduction and general concerns

The Global Strategy has been successful in helping to draw greater attention worldwide to the harmful use of alcohol, and meaningful results have been achieved in its implementation. As discussed in previous feedback from stakeholders and Member States during consultations on the Global Strategy and during formal discussions including the World Health Assembly, efforts to strengthen implementation of the Global Strategy should build on the global consensus represented in the Global Strategy.

Actions to strengthen implementation of the Global Strategy should remain focused on targeting harmful use of alcohol by providing Member States a menu of effective, evidence-based policy options and interventions that take into account varying national, religious, and cultural contexts.

To that end, our comments on the current working document will focus on several key concerns:

- I. The working document uses terminology imprecisely and does not consistently reflect the Global Strategy’s appropriate and specific focus on reducing “*harmful* use of alcohol” (emphasis added).
- II. The working document does not adequately acknowledge the significant progress made under the Global Strategy, is overly focused on a small subset of unproven policy interventions, and downplays evidence of successful policies and interventions, including in the United States.
- III. The working document takes an unduly negative view of engagement with economic operators and seeks to advance concepts that have repeatedly failed to gain consensus Member State support.

II. Action to strengthen implementation of the Global Strategy must consistently focus on harmful use of alcohol

As has been discussed in feedback from multiple Member States and stakeholders on previous WHO Secretariat reports during and after the 2019 online consultation, it is critical to retain focus on the Global Strategy's appropriate, specific, and Member State-endorsed goal to reduce *harmful* use of alcohol. The goal of the Global Strategy, as agreed by Member States, is to reduce harmful use of alcohol, not to target or eliminate all alcohol consumption per se. The current working document, in contrast, imprecisely differentiates between 'harmful use' and alcohol consumption per se throughout.

In addition to imprecise terminology, the working document emphasizes metrics like per capita alcohol consumption that are not relevant indicators for harmful use. For example, the working document argues that “[b]etween 2010 and 2018, no tangible progress was made in reducing total global alcohol consumption per capita...” (p 2) and proposes a new global target (Target 1.2, p 11) to reduce global per capita consumption while ignoring metrics that accurately measure the impacts of harmful use of alcohol.

As further examples, the working document refers, without evidence or specific citations, in Action Area 2 to the “nature and magnitude of alcohol-attributable public health problems” (rather than to impacts of harmful use) and proposes that Member States implement measures to reduce the levels of alcohol consumption among all drinkers rather than among heavy drinkers (p 13).

This shift in focus from harmful use of alcohol to all consumption contradicts not only the Global Strategy but also the language Member States agreed to and endorsed in the Global Action Plan on Non-Communicable Diseases (NCDs), the Political Declaration of the 2018 High Level Meeting on NCDs, and UN Sustainable Development Goal 3.5.

Failing to focus specifically on harmful use and its related impacts does not differentiate between light, moderate and heavy drinkers, or account for abstainers. Doing so is likely to reduce the effectiveness of proposed measures, as patterns of drinking are far more important than per capita consumption for understanding and reducing harmful use of alcohol. Numerous national experiences and published scientific papers show that:

- Reductions in per capita consumption do not necessarily reflect or predict reductions in harmful use of alcohol. For example, data from Sweden¹ and the United Kingdom² show that reductions in per capita consumption occurred at the same time as increases in hospitalization related to harmful use of alcohol.
- Measuring per capita consumption does not account for the effects of heavy episodic drinking (binge drinking). For example, per capita consumption of alcohol in the European Union increased by 2.6% from 2003 to 2007, during which time the proportion of binge drinkers did not increase. Per capita consumption decreased by 7.8% from 2007 to 2010, during which time the proportion of binge drinkers did not decrease.³
- Measuring per capita consumption does not account for the specific dangers of consuming unregulated and potentially dangerous illicit products. While commercial products have reliable record-keeping (based on official sales figures and taxation) records of non-commercial alcohol production and distribution are non-existent and

¹ Halgren et al., 2012.

² Meier, 2010.

³ <http://www.iwsr.co.uk/>

are speculative, and there is no information about patterns of consumption and ensuing diseases. Consumption of non-commercial and illicit alcohol increases in response to increased restrictions on legitimate products.⁴ Illicit alcohol is frequently contaminated with high levels of toxic properties like methanol, acetaldehyde, heavy metals, ethyl carbamate, coumarin, and diethyl phthalate, to name a few, that may cause health problems and even death.

III. Action to strengthen implementation of the Global Strategy must acknowledge and build on effective interventions and significant progress to date

The working document lists multiple areas where the Global Strategy has indeed succeeded in significantly reducing harmful use of alcohol yet overall downplays evidence of the Global Strategy's progress to date. In order to appropriately develop an action plan for strengthening implementation of the Global Strategy, it is critical to take unbiased stock of the progress achieved thus far, noting that metrics for measuring progress should focus on harmful use of alcohol as discussed in detail above.

The United States' experience in particular speaks to the progress that has been made under the Global Strategy, including through targeted interventions such as education, school-based programs, family-based interventions, screening and brief interventions, social norm approaches, and multi-component interventions that have been shown to be effective in addressing harmful use of alcohol.^{5,6} Numerous studies consistently support the efficacy of brief individual motivational interventions to prevent underage drinking and reduce the quantity and frequency of heavy drinking and alcohol-related problems.^{7,8}

The United States continues to make measurable progress in reducing harmful use of alcohol. In fact, there has been a 20 percent decline in alcohol use disorders in the U.S. since 2010. The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2019 National Survey on Drug Use and Health (NSDUH) survey shows record low prevalence of alcohol consumption among American youth, continuing a steady decline that has led to nearly 3 million fewer underage drinkers and 2.2 million fewer binge drinkers over the past ten years.

The number of 12- to 20-year-olds who have consumed any alcohol in the last month has declined nearly 30 percent since 2010 (falling from 26 percent in 2010 to 18.5 percent in 2019). In just the last four years, underage heavy drinking declined by 33 percent (from 3.3 percent in 2015 to 2.2 percent in 2019), and underage binge drinking decreased 17 percent (from 17 in 2015 to 11 percent in 2019).⁹

⁴ WHO, 2006; Loukomskaja, 1997; McKee, 1998; Partanen, 1993; Zaigrev, 2004).

⁵ Hingson R, White A. (2014). New research findings since the 2007 Surgeon General's Call to Action to Prevent and Reduce Underage Drinking: a review. *J Stud Alcohol Drugs.*, 75(1):158-69

⁶ NIAAA. (2014). Research-based strategies help reduce underage drinking. <https://niaaa.nih.gov/news-events/news-releases/nih-study-research-basedstrategies-help-reduce-underage-drinking>

⁷ Reynolds G.S., Bennett J.B. (2015). A cluster randomized trial of alcohol prevention in small businesses: a cascade model of help seeking and risk reduction. *Am J Health Promot.*, 29(3):182-91.

⁸ Cronce J.M., Larimer M.E. (2011) Individual-focused approaches to the prevention of college student drinking. *Alcohol Res Health.*,34(2):210-21.

⁹ National Survey on Drug Use and Health <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>

Additionally, in 2018 drunk driving fatalities declined 3.6 percent, continuing a steady decline that has seen drunk driving fatalities decrease 34 percent since 1991 and 50 percent since record keeping began in 1982.¹⁰

Evidence-based, effective measures such as those that have contributed to reducing harmful use of alcohol in the United States should be examined by the WHO Secretariat and by Member States seeking examples of effective policies, educational efforts and partnerships. While there is no one-size-fits-all policy to address harmful use, such proven effective policies should be included as possible best practices to help strengthen future implementation of the Global Strategy and should be reflected in the working document.

In contrast, the working document focuses overwhelmingly on a narrow subset of policy interventions contained in the WHO's SAFER initiative. SAFER is not a member-state endorsed document and does not reflect the full menu of policy measures endorsed by Member States in the Global Strategy. Nevertheless, the working document elevates this narrow subset of policies (including increased taxation, advertising or marketing bans and restricting availability), despite a lack of evidence or scientific data to support their effectiveness.

A. Excise Taxes/Pricing

Like taxes on other products, higher taxes may reduce overall purchases of beverage alcohol products. Higher prices, however, have little to no impact on harmful use of alcohol. In fact, heavy drinkers are least likely to be deterred by price.¹¹ Increased taxes are unlikely to be effective as a means to reduce binge drinking, regardless of gender or age group.¹²

In addition to having no impact on reducing harmful drinking, tax increases may also increase dangerous consumption of illicit alcohol.¹³ Studies clearly show that when taxes are increased, the consumption of illicit alcohol increases.¹⁴ This can result in acute and chronic adverse health consequences, due to uncontrolled and unregulated production methods and materials.¹⁵ Alcohol poisoning is prevalent in countries with significant unrecorded alcohol consumption.¹⁶

The working document further recommends Member States not only implement taxes on alcohol, despite a lack of evidence, but also earmark tax revenue. The working document does not make any mention of the WHO's own consideration of the

¹⁰ Data from the U.S. Department of Transportation's National Highway Traffic Safety Administration <https://www.nhtsa.gov/> and compiled by Responsibility.org <https://www.responsibility.org/blog/in-2018-drunk-driving-deaths-decreased-for-third-year-in-a-row/>

¹¹ An R, Sturm R. Does the response to alcohol taxes differ across racial/ethnic groups? Some evidence from 1984- 2009 Behavioral Risk Factor Surveillance System. *The journal of mental health policy and economics*. 2011 Apr;14(1):13.

¹² Nelson JP. Binge drinking and alcohol prices: a systematic review of age-related results from econometric studies, natural experiments and field studies. *Health economics review*. 2015 Dec;5(1):6.

¹³ Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB, Jha P, Mills A, Musgrove P, editors. *Disease control priorities in developing countries*. The World Bank; 2006 Apr 2.

¹⁴ Anderson P, Chisholm D, Fuhr DC. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *The lancet*. 2009 Jun 27;373(9682):2234-46.

¹⁵ Anderson P, Chisholm D, Fuhr DC. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *The lancet*. 2009 Jun 27;373(9682):2234-46.

¹⁶ Rehm J, Kanteres F, Lachenmeier DW. Unrecorded consumption, quality of alcohol and health consequences. *Drug and alcohol review*. 2010 Jul;29(4):426-36.

substantial arguments against earmarking, which include budgetary inflexibility and economic distortion.¹⁷

Lastly, the working document proposes a “global tax on alcohol,” with no consideration given to how such a tax would be designed or implemented.

B. Restricting Availability

Reducing alcohol outlet density and time of availability is not a panacea to reducing alcohol abuse, nor is it supported by the evidence as an effective way to combat harmful use of alcohol. Studies have shown that alcohol availability and alcohol outlet density are not tied to alcohol abuse. The relationship between neighborhood alcohol outlet density and alcohol related harms may differ due to variance in social, economic, demographic, and cultural factors as opposed to availability.^{18, 19}

In the United States, which has expanded availability greatly in the last 10 years, there has been no increase in the harmful use of alcohol. A review of 14 states that began to allow Sunday alcohol sales between 1995 and 2008 showed no increase in alcohol related traffic fatalities in 13 out of 14 states.²⁰ One study analyzed five Californian communities at the neighborhood level and did not find a relationship between outlet densities and consumption.²¹

Moreover, it is misleading to suggest that reducing the number of retail outlets will decrease the harmful use of alcohol given that illicit alcohol accounts for 25 percent of per capita consumption worldwide and as much as 60 percent in some countries.²²

C. Marketing Restrictions

U.S. spirits producers have been and remain fully committed to directing our advertising to adults of legal purchasing age in a responsible and appropriate manner. Restricting or banning advertising is not an effective harm reduction initiative.

The overwhelming body of scientific evidence shows that advertising does not cause an individual to begin drinking or abuse alcohol.²³ In fact, advertising studies have concluded that advertising merely drives brand choice by consumers among different types of alcohol.²⁴

¹⁷ WHO Arguments for and against earmarking https://www.who.int/health_financing/topics/public-health-taxes/for-against-sin-tax/en/

¹⁸“The ecology of domestic violence: the role of outlet density,” *Geospatial Health*, M Livingston, 5(1), 2010, pp. 139-149)

¹⁹ “Hierarchical additive modeling of nonlinear association with spatial correlations – An application to relate alcohol outlet density and neighborhood rates,” *Statistics in Medicine*, Q Yu, B Li, RA Scribner, 2009; 28: 1896-1912.

²⁰ Stehr MF, “The Effect of Sunday Sales of Alcohol on Highway Crash Fatalities,” *The B.E. Journal of Economic Analysis & Policy*, Vol. 10, Issue 1, Article 73, 2010.

²¹ Gruenewald PJ, Millar AB, Ponicki WR, Brinkley G. Physical and economic access to alcohol: The application of geostatistical methods to small area analysis in community settings. *The epidemiology of alcohol problems in small geographic areas*. 2000:163-212.

²² “Size and Shape of the Global Illicit Alcohol Market,” *Euromonitor International*, 2018.

²³ Nelson JP, Moran JR. Advertising and US alcoholic beverage demand: System-wide estimates. *Applied Economics*. 1995 Dec 1;27(12):1225-36.

²⁴ Gius MP. Using panel data to determine the effect of advertising on brand-level distilled spirits sales. *Journal of Studies on Alcohol*. 1996 Jan;57(1):73-6.; Wilcox GB, Kang EY, Chilek LA. Beer, wine, or spirits? Advertising's impact on four decades of category sales. *International Journal of Advertising*. 2015 Aug 8;34(4):641-57.

A review of U.S. spirits, wine and beer sales over a 40-year period found per capita consumption remained essentially constant, while advertising for beverage alcohol increased almost 400 percent.²⁵

According to a comprehensive review of advertising studies, longitudinal studies claiming to show a causal link between alcohol ads and youth drinking are scientifically flawed.²⁶ This review found “significant econometric and statistical problems, which preclude a causal interpretation.”²⁷ Among the studies’ flaws, the author reported problems with how researchers selected people to participate in their studies and how they drew conclusions from the data they collected.

Moreover, the vast majority of alcohol consumed worldwide is not advertised. Many beverages in developing countries are home produced or produced illicitly.

In the United States, commercial speech and the right to advertise are constitutionally protected under the First Amendment. Such First Amendment protection afforded to beverage alcohol advertising is equal in scope to the First Amendment protection afforded to the advertising of other legal products and services. Such free speech has not impeded declines in the United States of underage drinking and binge drinking, as noted above.

In sum, restrictions on advertising will not assist in reducing the harmful use of alcohol because the scientific literature shows that advertising does not cause an individual to begin drinking or to abuse alcohol.

IV. Action to strengthen implementation of the Global Strategy must acknowledge the critical role and benefits of engagement with economic operators

The Global Strategy acknowledged that the alcohol industry has a role in helping to secure the shared goal of reducing harmful use of alcohol, including through self-regulatory actions and initiatives. This role was reaffirmed in the 2018 Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (NCDs), and the Final Report of the WHO High-Level Commission on NCDs recommended further strengthening WHO’s engagement with the private sector, including through public-private partnerships.²⁸ This inclusive approach should be reflected in revisions to the working document.

While the working document proscribes limited roles for and engagement with economic operators, the document as a whole treats economic operators in isolation and with suspicion rather than a constructive view toward maximizing the value of partnership, dialogue, and coordination. It is particularly troubling that the WHO Secretariat continues to suggest potential need for a “global normative law on alcohol at the intergovernmental level” without clearly stating that such a model was explicitly not supported by Member States during the 2020 World Health Assembly (to cite only the most recent example).

²⁵ Wilcox GB, Kang EY, Chilek LA. Beer, wine, or spirits? Advertising's impact on four decades of category sales. *International Journal of Advertising*. 2015 Aug 8;34(4):641-57.

²⁶ Nelson JP. Alcohol marketing, adolescent drinking and publication bias in longitudinal studies: a critical survey using meta-analysis. *Journal of Economic Surveys*. 2011 Apr;25(2):191-232.

²⁷ Nelson JP. Alcohol marketing, adolescent drinking and publication bias in longitudinal studies: a critical survey using meta-analysis. *Journal of Economic Surveys*. 2011 Apr;25(2):191-232.

²⁸ <https://www.who.int/ncds/management/time-to-deliver/en/>

As demonstrated by experience in the United States, sound, effective efforts to address harmful use of alcohol require evidence-based measures and technical collaboration across the whole of society, including with economic operators. In fact, the significant progress in reducing harmful use of alcohol in the United States results in large part from effective targeted interventions and education initiatives, several of which are conducted in cooperation with economic operators. Examples include:

- *Ask, Listen, Learn: Kids and Alcohol Don't Mix* is a neuroscience-focused program that teaches 9- to 12-year olds about alcohol's impact on developing brains through an innovative series of animated videos and corresponding lesson plans aligned with educational standards.²⁹ Presenting the negative impact of underage drinking in a unique and digestible way to kids and encouraging conversations between youth and parents, educators and other adult caregivers makes an important contribution to the 50 percent decrease in lifetime underage drinking from 2003 to 2016 reported in the CDC's Monitoring the Future survey.³⁰
- *Ask, Listen, Learn* partners with an array of education organizations including Discovery Education, the American School Counselor Association (ASCA), the National Association of School Nurses (NASN) and Classroom Champions. *Ask, Listen, Learn* and other private sector led initiatives, including *Alcohol 101 Plus*, *Parents, You're Not Done Yet*, and the Virtual Bar have also contributed to a significant decline in binge drinking among college students, which has decreased 34% proportionally from 43% in 1991 to 28% in 2018.³¹
- *We Don't Serve Teens* is a consumer education campaign developed by the U.S. Federal Trade Commission and promoted by partners including state alcohol regulatory agencies, state and local law enforcement, alcohol industry representatives, high schools and colleges, and social services organizations. *We Don't Serve Teens* materials are available free of charge in English and Spanish, and the campaign's effectiveness has been recognized by the U.S. Senate and House of Representatives, the National Prevention Council, and governments of more than 40 U.S. states. According to the 2018 Monitoring the Future survey data, since the *We Don't Serve Teens* initiative launched in 2006, the ease of obtaining alcohol has dropped nearly eight percent proportionally among high school seniors and 15 percent among 10th graders.
- Aggressive, innovative education and enforcement campaigns conducted in partnership with economic operators, among other partners, have also contributed to the sustained decline in drunk driving deaths in the United States. For example, the use of ignition interlock devices has prevented repeat (high-risk) drunk drivers from starting their cars if they have been drinking alcohol while still allowing them to remain productive in society.

V. Conclusion

We applaud the positive progress made over the past decade in reducing the harmful use of alcohol, particularly regarding significant declines in heavy episodic drinking, underage drinking, and alcohol-related mortality and morbidity.

²⁹ <https://asklistenlearn.org/>

³⁰ CDC Monitoring the Future Survey <https://www.drugabuse.gov/drug-topics/trends-statistics/monitoring-future>

³¹ *Ibid.*

We firmly believe that all actions taken to strengthen implementation of the Global Strategy must build upon this progress and remain consistent with the Global Strategy's Member State-endorsed objectives and approaches. We look forward to an open and constructive dialogue about productive and effective measures to achieve the shared goal of reducing the harmful use of alcohol.

Thank you again for the opportunity to provide the U.S. distilled spirits industry's views. Please do not hesitate to contact us if we can provide additional information.

Drinkaware

Country/Location: Ireland

URL: www.drinkaware.ie

Submission

1. SUMMARY

“The vision behind the Global Strategy is improved health and social outcomes for individuals, families and communities”, is one with which Drinkaware (Ireland) can identify. Our public health remit as a national charity is to prevent and reduce the misuse of alcohol and tackle underage drinking, and our ability to deliver impact in this regard is evident in our 2019 Annual Report

<https://www.drinkaware.ie/wp-content/uploads/2020/11/2019-Drinkaware-Annual-Report-and-Financial-Statements.pdf>

The magnitude of the health and social burden regarding alcohol misuse, inevitably exacerbated by the Covid-19 pandemic, has heightened the need for greater action and therefore greater co-ordination, collaboration and coherence, if alcohol misuse and harms are to be addressed.

Prevention is critical and best practice prevention requires collective action because shared responsibility does not lessen impact but has the potential to amplify it. There are many potential stakeholder synergies at our disposal, including those the WHO refers to as Best Buys - knowledge sharing and transfer, and capacity building across community, civil society and health practitioners. Prevention and intervention coalitions should be encouraged amongst mission-aligned organisations to co-create effective and efficient action. This point is further expanded in the sections below.

Actions to reduce harm should include and maximise known protective measures such as knowledge of harms, self-awareness & self-regulation, parental role modelling, etc. The known protective and buffer factors, including those with evidence-based behaviour change logic, need to be amplified and utilised.

Capacity building is referenced throughout and there is an opportunity to leverage the experience and capacity of non-state actors, civil society and community groups to deliver impactful progress.

It is critical from a harm prevention perspective, that not just past and present behaviour is analysed, but also potential future attitudes and behaviours must be extrapolated and explored, and comprehensive scenario planning and contingency strategies devised.

As the Document states, “There is a need to strengthen the role of civil society in alcohol policy and implementation”, and as elaborated here there is an identifiable role to also involve these organisations in complementary campaigns and programmes that support policies and state programmes, particularly in the areas stated. Alcohol use has multiple social, economic and environmental determinants, and all dimensions and determinants need to be considered because the accumulative benefit of doing so will have the greatest impact on people’s drinking and their physical and mental health and wellbeing. Whilst economic and environmental determinants are primarily within government’s remit, the social determinants can be affected by societal, community and individual action. There is an intrinsic and evidence-based value in knowledge, self-awareness and self-regulation of attitudes and behaviours.

The Working Document notes some positive data, and there is evidence - in Ireland amongst other countries - of a growing movement and interest in healthier drinking behaviour. There is therefore an opportunity to create & nurture lasting change and narrative that supports this should be encouraged. Consistently pre and during Covid, national Irish data shows a sustained interest amongst the adult drinking population in changing their drinking behaviour (Barometer 2019, 2020). Converting this interest into intent, and then enabling it to be acted upon are potential turnkey solutions that are currently being deployed and should be aggregated to increase their impact and reach.

Communicating these positives, in addition to the harms regarding alcohol, is a critical element of affecting durable change because it demonstrates self-efficacy and a viable alternative social norm, as well as the real benefits of healthy behaviour.

2. Drinkaware's commentary and suggestions regarding the main body of the Working Document:

2.1 The Context of Covid-19

- The Working Document states that there is “emerging evidence of an increase in alcohol consumption in some population groups during Covid-19 pandemic”. Our national Barometer survey, as an ongoing series (2017, 2018, 2019, 2020) that identifies attitude, behaviour and consumption patterns and trends, corroborates this point (stats)
- Covid-19 has heightened the need for continuous and vigilant health surveillance that also needs to be sufficiently broad to encompass the multiple social, sociological, economic and environmental dimensions and determinants of alcohol usage. These go beyond sales and consumption and should include lifestyle, mental health, household make-up, etc. factors, and policy and programme coherence regarding same is essential.
- Stress is toxic to good mental and physical health and wellbeing, and people's exposure to increased levels of stress, anxiety, loneliness, uncertainty during the pandemic has impacted on both exponentially. A driving motivator for consumption is 'coping' and during the pandemic the patterns of drinking have changed for many population groups as the reasons to drink to cope are increasing (Ireland's CSO data shows loneliness, depression and nervousness have all increased across all age groups, and this tallies with Drinkaware data that those who are drinking during Covid are doing so to cope (our stats on Increase in household tension; Drinking to cheer up when in a bad mood or stressed; Drinking because it helped when you're depressed or anxious)

2.2 Youth populations

- As stated: “young people are disproportionately affected by alcohol”. And a worrying theme of the emerging evidence in Ireland, that is likely replicated in other markets, is that this is also a population group that has been most adversely affected by the Covid-19 pandemic, in economic, educational, social and mental health terms. The combination of these disproportionate impacts, places young people in a highly vulnerable position that merits specific focus in terms of preventions and interventions.
- Primary prevention is key and of additional and related importance is the inter-generational transmission of habits, behaviours and attitudes regarding alcohol. This can result in the development of children's and young adult's unhealthy habits, behaviours and attitudes to alcohol now and in the

future. If unhealthy habits are being formed and embedded now during this crisis, particularly in family households, then pro-active, empathetic support is needed.

2.3 Low awareness & acceptance

- There is a clear need to communicate harms, but in a way that will be well received and assimilated. This requires deep understanding of the social conventions, norms, language as well as attitudes, motivations and behaviours of the target population groups. Shared learning and experiences from other non-state actors, civil society and community groups can be leveraged to this end.
- In addition, better usage of digital and social platforms could also deliver wider awareness and again these stakeholders could provide this support where technical capacity is lacking.
- Acceptance of the negative impact of alcohol consumption on health is low and “health literacy and health consciousness of the general public” needs to increase. There are contributing factors to ‘acceptance’ and applying behaviour change logic can improve take-up and critically, the conversion of intention to action. Involving the stakeholders who are already working in this area means potentially enhancing success and harnessing the reach and learnings of best practice behaviour change and social marketing.

2.4 Persistent and growing health inequality

- Inequality obstructs wellbeing and there are numerous health inequities with regard to alcohol harm that need to be addressed. There are already societal constituencies who experience greater harms and as with any crisis, Covid has the potential to further exacerbate this. Specific steps with targeted action need to be taken for these vulnerable groups.
- It is also advisable to re-assess the accepted determinants of alcohol usage as these will have evolved and are undoubtedly still evolving during the pandemic.

3. Drinkaware’s commentary and suggestions regarding specific sections of the Working Document:

3.1 Operational objectives, principles and key areas of the action plan

- Reference is given to the “best available evidence” and it is therefore logical that this encompasses access to broad related studies. Richer contextual insight and analysis can be provided by investigating the drivers and motivations, as well as attitudes and behaviours regarding alcohol consumption. For example, our 2020 Barometer collated household as well as individual experiences to provide a clearer picture on what’s actually happening, and the consequences of Covid-19 and the related restrictions.
- Health and wellbeing surveillance is key to really understanding the motivations, viewpoints and the attitudes and behaviours regarding alcohol. However data on consumption alone is not sufficient and average figures do not tell the whole story. The continuous and open sharing and application of broad insights, learnings, experiences and research is critical to the formulation of effective preventions and interventions.

- “Empowering of people and communities” is a principle that delivers self-efficacy and enables change and benefits from the application of known best-practice behaviour change tools. The evidence-informed and evidence-based tools and campaigns that organisations like Drinkaware Ireland have delivered with measurable impact, can be leveraged and shared to support this principle.

3.2 Action Area 2: Advocacy, awareness and commitment

- As intimated in the Working Document, the deficit of effective and comprehensive communication has inevitably contributed to the lack of awareness and knowledge referenced throughout. “Modern communication technologies and multi media materials are needed” and both the knowledge and experiential resources and capacity of civil society and community groups are potential available sources for this.
- Evidence shows the importance of primary prevention programmes and the need for widespread alcohol education for children is therefore critical. Best practice indicates how alcohol education in schools can be delivered and Drinkaware (Ireland)’s Alcohol Education Programme for 12-15 year olds (1st, 2nd, 3rd year secondary school students) based on this, has been independently evaluated (Maynooth University) and proven to be effective in increasing knowledge, delaying first drink and sustaining negative harms. The sharing of this data, experience and learnings may be beneficial to other countries.
- Regular reportage on harms is flagged as an action (5) but extending this to encompass determinants perhaps peripheral but still relevant and contributing factors to the antecedents of consumption and misuse, will provide further valuable insights and considerations for preventions and interventions.

4. Of related note from Drinkaware’s Response to the Discussion Paper on the Implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol in November 2019

Two challenges cited have evolved:

1. The social norm regarding the acknowledged but accepted nature of excessive alcohol consumption, has now transformed and is likely to be still transforming and it will not be until the pandemic has plateaued or passed that a new norm can be truly contemplated. On the plus side, if not yet embedded, then a window exists to shape these transforming norms
2. The trust deficit described is still a factor albeit that in some instances and for some institutions it will have altered positively. It will still however be helpful to leverage the goodwill and engagement potential of all ‘trusted’ actors.

Three of the priority areas cited still remain key and are further discussed above:

- i. Collective knowledge &resourcing
 - ii. Health inequities and health literacy
 - iii. Capacity building and behaviour change best practice
4. About Drinkaware

Drinkaware is the national charity (Registered Charity Number: 20204601) working to prevent and reduce alcohol misuse in Ireland and our vision is an Ireland where alcohol is not misused. Achieving this requires independence, ambition, trust, credibility and collaboration.

Drinkaware's charitable purpose is 'to benefit the community by preserving, protecting and promoting public health and socially responsible behaviour by reducing alcohol misuse and related harm.'

Drinkaware is governed by an independent board and regulated by the Charities Regulator. We are committed to maintaining the highest governance and transparency standards.

We are committed to an evidence-based approach, conducting robust research to inform our work in three key areas – reducing alcohol misuse, tackling underage drinking and supporting alcohol education – and proactively ensure our resources and programmes are externally evaluated to assess their efficacy.

Drinkaware's social contract – to prevent and reduce the misuse of alcohol, and tackle underage drinking – is a citizen-driven social purpose - supported by 86% public awareness 'to provide trusted information on alcohol' (Barometer 2020). As a civil society organisation, Drinkaware's role is to encourage voluntary behaviour change. We are a trusted and known champion of positive behaviour change through improved health literacy and citizen and community empowerment. And we therefore support any and all co-operative and collaborative opportunities to leverage our trusted relationship with citizen and communities across the country, to engage and empower them accordingly.

ENDS

Attachment(s): 0

Drinks Ireland

Country/Location: Ireland

URL: www.drinksireland.ie

Submission

Drinks Ireland appreciates the opportunity to participate in this consultation. We believe the industry has already been playing a key role in reducing alcohol related harm. It is the view of Drinks Ireland that by collaborating with other key stakeholders, such as public health officials and non-Government organisations, is the best way to achieve the aims of the global strategy to reduce the harmful use of alcohol.

Attachment(s): 1

00422_60_drinks-ireland-submission-to-the-who-december-2020.pdf



Submission to the World Health Organisation on its working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

December 2020

Introduction

A decade ago, the World Health Assembly (WHO) endorsed the Global Strategy to Reduce the Harmful Use of Alcohol which followed a collaboration between WHO member states, non-governmental organisations (NGOs) and economic operators. The purpose of the strategy was to support and complement public health policies in Member States. As part of this consultation process in the development of the strategy's action plan, Drinks Ireland would like to submit its own observations to the WHO's draft plan that has been circulated.

Our sector is strongly committed to a number of important self- and co-regulatory initiatives in Ireland in key areas of the global strategy and has long invested in a broad range of responsible drinking initiatives, reducing underage drinking and regulating promotion of alcohol.

Drinks Ireland

Drinks Ireland, a trade association of Ibec clg, represents 61 producers and distributors of alcohol beverages on the island of Ireland, together employing over 175,000 people across breweries, distilleries, suppliers, distributors, and the hospitality sector. Drinks Ireland is committed to encouraging responsible choices about alcohol and believes that for most adults of legal drinking age, moderate alcohol consumption can be part of a well-balanced lifestyle.

Drinks Ireland welcome the opportunity to participate in this consultation on this global strategy and appreciate that the WHO has facilitated dialogue with economy operators.

Alcohol Consumption in Ireland

It is encouraging to note that harmful use of alcohol is in decline across Europe, as evidenced in WHO reports. Specifically, it is welcome to see that heavy-episodic drinking, youth drinking and drink-driving have all experienced significant declines. Ireland has also seen significant changes when it comes to alcohol misuse and underage drinking. Since 2001, average per adult alcohol consumption has fallen by 23.2% in Ireland. Drink-driving fatalities have declined by 37% in Ireland between 2006 and 2016.

The ESPAD 2015 report shows that for students in Ireland aged 15 to 16 years old, the lifetime use of alcohol declined by 18% between 1995 and 2015. The 2019 report shows Irish teenagers as the eighth lowest (out of 35 European countries) in terms of frequency of alcohol intake in the last 30 days by gender. Furthermore, Irish teenagers rank 24th out of 35 in terms of the prevalence of heavy episodic drinking at least once in the last 30 days.

Drinks Ireland Observations

Drinks Ireland would like to raise seven key points in response to the publication of the working document on the Global Strategy to Reduce the Harmful Use of Alcohol in the following sections.

1. A focused approach to tackle alcohol misuse

Drinks Ireland believes that more targeted measures must be supported at tackling alcohol related harm as opposed to recommendations aimed at reducing overall consumption. There is little proof that broad sweeping measures around taxation, a minimum unit price on alcohol, warnings on labels and certain advertising restrictions will impact the behaviour of individuals that consume alcohol in a harmful manner. Such measures only appear to reduce consumption among low-risk or moderate drinkers. This would be in line with the UNPD.

In Ireland, industry led education measures around the harmful use of alcohol, particularly among young people has yielded positive behavioural changes which has led to a reduction in alcohol / heavy episodic drinking among teenagers in Ireland. Furthermore, the Department of Health in Ireland noted the estimated total cost to Irish society of problem alcohol use is €2.351 billion in 2013. The figures estimated in this paper show a significant decrease in the estimated cost to society between 2007 and 2013. The estimated social costs for 2007 was €3.7 billion.

The conflation of harmful alcohol consumption and per capita consumption of alcohol is in contradiction to the title and primary objective of the Global Strategy to Reduce the Harmful Use of Alcohol.

2. Industry contribution in reducing harmful alcohol use

The drinks industry has made a positive contribution to reducing the harmful use of alcohol which has been done through its own expertise on analysing consumption behaviour. This working document should acknowledge the industry's track record on executing campaigns and programmes designed to reduce alcohol related harm and not portray the drinks sector as a barrier to progress.

The drinks industry funds a range of measures that are designed to reduce alcohol related harm in society.

DrinkAware

Drinkaware is the national charity working to prevent and reduce alcohol misuse in Ireland, governed by an independent board and regulated by the Charities Regulator. They do this through evidence-informed programmes at community level with the public and online, through secondary school teachers and in workplaces.

The national research that DrinkAware commissions encourages greater understanding of alcohol consumption and its impact. The health promotion resources they provide offer practical ways to drink less or cut out alcohol to protect health and wellbeing. Ultimately, DrinkAware's aim is to achieve two ambitious goals:

- 1) Delay the age of first drink, and
- 2) Reduce the number of adults who drink above the HSE low-risk weekly guidelines.

The WHO recommends a multi-faceted approach to reducing alcohol misuse and harm which the industry is keen to continue.

Responsible Serving of Alcohol (RSA) Programme

The RSA programme is an independently owned training organisation operating since 1999. They specialise in training and education in the service, sale and consumption of alcohol. The people that participate in the programme are the owners, managers and staff of Irish Licensed Premises.

All its training courses offer the most up to date information for participants including latest legislation and advice on the development of safety policies and procedures. Ultimately the programme helps to build confidence when handling difficult situations and making choices in relation to the sale, service and consumption of alcohol. The RSA Programme Ireland is supported by Fáilte Ireland (tourism body), An Garda Síochána (police) and the Royal College of Physicians of Ireland.

3. Incorporate economic operators to tackle alcohol related harm

Drinks Ireland believe that measures to tackle alcohol misuse and underage drinking should continue and that cooperation between public, private and civil society stakeholders is very important when it

comes to meeting these achievements. We believe that measures to tackle alcohol misuse and underage drinking should be evidence based and shown to work.

Holistic Approach

Drinks Ireland recommends a holistic approach to policy development and implementation and recommends that these policies focus on the reduction of harmful use of alcohol, not simply alcohol consumption in general. Drinks Ireland believes that a much greater emphasis must be placed on better informing Irish consumers about the Health Service Executive's low risk guidelines. Research from DrinkAware shows that less than 3% of Irish adults can correctly identify the HSE low-risk guidelines for alcohol consumption.

Department of Health – cooperation with AMCMB

The Alcohol Marketing Communications Monitoring Body (AMCMB) was established to oversee the implementation of and adherence to the voluntary codes of practice on placement and sponsorship to limit the exposure of young people to alcohol advertising. The AMCMB comprises of representatives from advertising standards authorities, the Department of Health, and economic operators. The successful management and adherence to this code is a good example of collaboration between economic operators and public health officials.

4. The impact of Covid-19

Covid-19 has had a devastating impact on the hospitality sector globally, but it has been notably worse in Ireland, due to the very restrictive rules on hospitality venues operating here, in particular on “wet pubs”, which have been closed since mid-March 2020. Ireland's experience sector contributes €4.5 billion in wages, salaries, and employment taxes every year. More than 330,000 people, many of them young workers, are either employed directly or supported directly by demand from the sector. Regrettably, recent actions by the Irish government, such as the continuing closure of Ireland's wet pubs, will result in these businesses being forced to permanently close. The knock-on devastation that this will have to individuals, families and communities will be immeasurable.

Drinks Ireland does not support any regressive measures that limit the availability and sale of alcohol during the pandemic. These reactive measures currently in place in many jurisdictions, such as reduced trading hours, alcohol sales bans and the closure of hospitality outlets are not supported by any evidence that it has played a role in reducing Covid cases. While the measures are short term, there is no merit in considering any of these measures for long term policy development.

While the Covid-19 pandemic has demonstrated the importance of a whole-of-society approach to protecting health there is little evidence linking excessive alcohol consumption at hospitality outlets to the spread of Covid-19. In Ireland, where much of the hospitality sector has had to endure severe lockdown measures, only 0.3% of cases were related to the sector.

In Ireland many alcohol producers participated in the national effort to combat against the spread of Covid with manufacturers producing hand sanitizer and allocating physical advertising space to Government advice on hand hygiene. Many of these measures have been welcomed by the WHO.

The working document tentatively suggests that consumption has increased during the pandemic, noting that there is some evidence of an increase during the early stages of the pandemic amongst some segments of the population. The draft should avoid references to COVID-19-related consumption until more data become available. It is worth noting that alcohol consumption in Ireland 2020 from January to September is down 4.5% compared to the same period in 2019.

5. Marketing and Advertising

The marketing and advertising of alcohol brands is becoming more regulated with consistently high standards across Europe. In Ireland, the industry has for decades abided by some of the strictest marketing codes in the world that govern the content and placement of advertising. The Irish Government has moved to regulate in this area with the enactment of the Public Health (Alcohol) Act 2018, which places restrictions on the content and placement of advertisements.

In Ireland, as in most developed countries, it is illegal to target adolescents in any marketing campaign. The statements in the draft that suggest that the industry is targeting minors in advertising should therefore be removed. Drinks Ireland believes that an ongoing dialogue with the private sector and relevant stakeholders is fundamental as it has yielded positive results in Ireland. For example, the Alcohol Marketing Communications Monitoring Body (co-funded by the Department of Health and the drinks industry) still monitors the advertising codes on placement of advertising in Ireland (pending the full enactment of the Public Health (Alcohol) Act 2018). It is a collaborative process between health officials, advertising bodies and the industry. It has led to the drinks industry being the 'best in class' when it has come to adhering to the advertising placement codes. The content of all ads must be submitted in advance for pre-clearance through Copyclear (which is funded by the drinks companies) to ensure they are compliant with the voluntary code (pending the full enactment of the Public Health (Alcohol) Act 2018).

6. Labelling

The working document proposes that member states implement labelling requirements for alcoholic beverages which displays essential information on ingredients, calorific value and health warnings. The Irish Government has enacted the Public Health (Alcohol) Act 2018, which includes measures for mandatory requirements of nutrition information and health warnings (including a warning on cancer) on all pre-packaged alcohol products sold in the Republic of Ireland. Regulations setting out the content of the warning labels will be drawn up and submitted to the EU Commission for review under both the TRIS and FIC requirements, prior to the Irish Minister signing the commencement order.

In 2019, Drinks Ireland, via the Brewers of Europe and spiritsEurope signed two memoranda of understanding with the European Commission. The Brewers of Europe Memorandum of Understanding calls for the voluntary inclusion of nutrition and ingredient information on all pre-packaged alcohol products. The spiritsEurope memorandum of understanding calls for voluntary nutrition information on-label and ingredient information on-line.

Drinks Ireland does not support the inclusion of misleading and sensationalist health warnings on any alcohol product and in particular a statement linking alcohol consumption to fatal cancers. The link between alcohol and cancer is complex and cannot be simply summarised on a label. Furthermore, the prospect of having a mandatory requirement on all alcohol products sold in the Republic of Ireland is a barrier to trade and thus would undermine the EU Single Market.

7. Taxation

Alcohol has become more affordable as Ireland has become more affluent. However, an increase in excise duty on alcohol is a blunt instrument that is unlikely to have a long-term impact – especially in a country like Ireland which is likely to see the standard of living and wealth of society increase in the coming years.

There is little correlation between excise increases and the decline in alcohol related harm or reduction in per capita consumption. Ireland has the second highest overall alcohol excise tax in the EU. We have the highest EU excise tax on wine, the second highest tax on beer and the third highest

tax on spirits. Whilst there has been no increases in excise in Ireland since 2013, consumption per capita has steadily declined.

Excise increases are a regressive tax that tend to have a greater impact on those from a lower socio-economic background and moderate drinkers.

Conclusion

Drinks Ireland appreciates the opportunity to participate in this consultation. We believe the industry has already been playing a key role in reducing alcohol related harm. It is the view of Drinks Ireland that by collaborating with other key stakeholders, such as public health officials and non-Government organisations, is the best way to achieve the aims of the global strategy to reduce the harmful use of alcohol.

DrinkWise Australia

Country/Location: Australia

URL: drinkwise.org.au

Submission

DrinkWise Australia is pleased to contribute comments to inform the development of a global action plan to support ongoing implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

DrinkWise recommends that the development of an action plan to continue implementation of the global alcohol strategy include:

- a range of actions that can target harmful alcohol consumption, reflective of national and local circumstances
- effective and consistent education that can build individual and community capacity to make informed decisions about alcohol
- approaches to education that are insight-driven and targeted to at-risk groups
- whole-of-community approaches that include social aspect organisations, academics, governments, health providers and industry, all playing a role to amplify consistent information and programs that reduce alcohol-related harm
- ongoing monitoring of the impacts of harmful alcohol consumption and programs designed to reduce harms.

Our submission is enclosed.

Attachment(s): 1

00297_63_drinkwise-submission-to-who-s-proposed-action-plan-to-implement-who-global-alcohol-strategy-11-december-final.pdf

Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Introduction

DrinkWise Australia is pleased to contribute comments to inform the development of a global action plan to support ongoing implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

DrinkWise is an independent, not-for-profit organisation focused on the prevention and reduction of the harmful consumption of alcohol, through a sustained approach to broad-based and targeted education.

Founded in 2005 by alcohol industry and government contributions, DrinkWise has played a significant role in a continued generational shift around Australians' alcohol consumption. Australia is now a society more defined by moderation than excess when it comes to alcohol and as a key stakeholder contributing to this cultural change, DrinkWise offers insights that reflect the effectiveness of a sustained, integrated, engaging and whole of community approach that could feature in the suite of options in a global action plan.

Australia's National Alcohol Strategy

For more than 30 years in Australia, the federal, state and territory governments have collaborated to provide a national policy framework to prevent and minimise alcohol-related harms among individuals, families and communities.

The current Australian National Alcohol Strategy 2019-2028¹ ('the Strategy') continues the long-standing national commitment to preventing and tackling harmful alcohol use through a combination of education, law enforcement, prevention, early intervention and health care strategies that are implemented by a range of government, non-government, commercial and not-for-profit organisations.

The Strategy reiterates Australia's commitment to the:

- . World Health Organisation (WHO) Global Action Plan for the Prevention of and Control of Non-Communicable Diseases 2013–2020, which includes a voluntary target of a reduction in harmful alcohol consumption of 10% by 2025.
- . WHO's Global Strategy to Reduce Harmful Use of Alcohol.
- . The United Nations 2030 Agenda for Sustainable Development Goals.

The Strategy provides a mix of regulatory, semi-regulatory, co-regulatory and voluntary approaches, that has enabled the achievement of significant positive changes in the way Australians drink alcohol. Evidence of Australians' improved relationship with alcohol can be seen through the statistically significant increase in moderate drinkers² and significant decreases in risky (harmful) alcohol consumption³ in the Australian population.

¹ <https://www.health.gov.au/sites/default/files/documents/2020/11/national-alcohol-strategy-2019-2028.pdf>

² DrinkWise Australians and Alcohol studies, 2007, 2016, 2018, 2020

³ Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019.

<https://www.aihw.gov.au/getmedia/cd005d19-1ebc-47f5-a46e-1cefb97e74be/aihw-phe-270-Chapter3-Alcohol.pdf.aspx>



DrinkWise activities in support of Australia’s National Alcohol Strategy

The drinking culture in Australia has changed significantly in recent years, to one that is safer and healthier. Rates of risky (harmful) drinking have declined and there is a clear proportion of the population choosing not to consume alcohol, with abstinence rates amongst the broader population continuing to increase (currently 23.8%). Importantly, abstinence rates amongst underage teenagers and pregnant women have increased and the introduction of mid, low and zero alcohol products provides options for those wanting to lower their overall alcohol consumption while still socialising with a drink.

The Strategy recognises that alcohol-related harms are not experienced uniformly across the population, with disproportionate levels of harm being experienced within some contexts and communities. As such, priority populations are highlighted in the Strategy and a range of policy approaches are nominated as viable options to build community and individual capacity. This will assist in encouraging further positive cultural change by shifting attitudes and practices from harmful alcohol consumption to moderate and low-risk use.

Education is a critical component to attitudinal and behavioural change and the DrinkWise approach is premised on the World Health Organisation’s Health Literacy foundation that communication campaigns are most effective when consumers receive consistent and sustained messaging and information in a range of settings and across multiple mediums⁴.

DrinkWise recognises that educating at-risk groups, through an evidence-based approach and best practice communication tactics, can contribute to positive changes if a sustained and consistent approach is applied. Examples of our approach and impact follow:

⁴ World Health Organisation 2013 – Health Literacy, the Solid Facts.
http://www.euro.who.int/_data/assets/pdf_file/0008/190655/e96854.pdf?ua=1

- **Abstinence in pregnancy and while underage**

DrinkWise has been actively increasing community awareness of the risks of consuming alcohol when planning a pregnancy, while pregnant and breastfeeding, through its Fetal Alcohol Spectrum Disorder (FASD) Awareness Program. By promoting an enduring message of abstinence from alcohol when pregnant, across multiple channels and settings that reflect the lived experience of women, their partners, families and friends, DrinkWise has helped raise awareness of FASD and has contributed to the significant increases in pregnant women abstaining from alcohol – from 40% in 2007 to 65% in 2019. <https://drinkwise.org.au/our-work/drinkwise-fasd-awareness-program/#>.

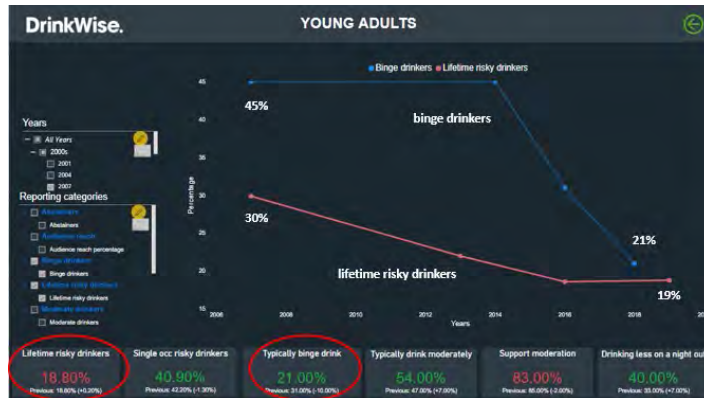
By continuing a sustained focus of abstinence for minors (underage), through supporting parents to be good role models and delaying the introduction of alcohol to their children, DrinkWise is contributing to the prevention and reduction of harmful alcohol consumption in adolescence and the risk of developing alcohol use disorders later in life. <https://drinkwise.org.au/our-work/parents-campaign/#>

The Australian Institute of Health and Welfare’s 2019 [data](#) released in July 2020 confirmed that 73% of minors aged 14-17 years continue to abstain from alcohol. The increase in abstinence by this age group has risen from 40% in 2007, when DrinkWise first commenced its parental influence campaigns that positioned [role modelling](#) and the [prevention of the supply of alcohol to minors](#) as parenting strategies that could impact the prevalence of underage drinking.



- **Young adults reducing harmful consumption**

By inspiring young adults who chose to consume alcohol to do so in moderation, DrinkWise is contributing to the prevention and reduction of excessive drinking behaviours and the associated harms that can result. <https://drinkwise.org.au/our-work/drinking-do-it-properly/#>. Binge drinking in this age group has declined from 31% in 2016 to 21% in 2018, while those drinking at levels harmful to longer-term health has nearly halved during the same period.



DrinkWise activities – inclusive of whole-of-community (or, whole-of-community approach?)

The Strategy recognises that preventing and minimising alcohol-related harms cannot be achieved by governments alone and that coordination and collaboration across jurisdictions, portfolios and the community is essential. It specifically recognises that the alcohol manufacturing industry, wider retail and hospitality industries, advertising, broadcasting and sporting industries play a significant role in Australia’s economy and social fabric. These industries have a desire and responsibility to support and take appropriate action to prevent and minimise alcohol-related harms through the lawful, responsible supply of alcohol and their ability to promote responsible and moderate consumption.

The DrinkWise model is based on an inclusive collaborative approach with influential corporate and for-purpose partners. A long-term industry commitment to funding by industry producers has allowed DrinkWise to take a generational approach to research programs and communications, essential for achieving lasting behavioural and cultural change.

Substantial and sustainable options to reduce harmful drinking are more likely to be achieved with industry consultation than without it. As an example, DrinkWise leverages alcohol industry channels, such as those within retail environments, to deliver point-of-purchase moderation messages. This not only allows access to an important channel but illustrates the commitment from retailers to collaborate with DrinkWise to promote responsible consumption⁵.

Partnerships have assisted in amplifying DrinkWise’s programs by promoting consistent information across multiple channels and settings that reflect the lived experience of consumers. This whole-of-community approach is a hallmark of the DrinkWise model and its impact in Australia and could effectively be applied in other countries to support the global alcohol strategy.

Alcohol consumption impacts resulting from COVID-19

DrinkWise continues to monitor consumption research findings during COVID-19 and notes that various findings conclude that the majority of Australians have not increased their consumption, and, on average, Australians are drinking within recommended government guidelines.

In recognition that consumption had increased for some Australians and that this was potentially the result of stress, anxiety or depression as result of movement restrictions that were put in place,

⁵ <https://drinkwise.org.au/our-work/choose-to-drinkwise/#>

DrinkWise developed a range of new initiatives to discourage harmful alcohol consumption by encouraging moderation, positive role modelling and the promotion of support services and counselling⁶⁷⁸.

Conclusion

Australian's relationship with alcohol has significantly improved and is testament to the effectiveness of a co-ordinated national policy framework that provides a range of actions that can be adopted to reflect national and local circumstances.

DrinkWise recommends that the development of an action plan to continue implementation of the global alcohol strategy include:

- a range of actions that can target harmful alcohol consumption, reflective of national and local circumstances
- effective and consistent education that can build individual and community capacity to make informed decisions about alcohol
- approaches to education that are insight-driven and targeted to at-risk groups
- whole-of-community approaches that include social aspect organisations, academics, governments, health providers and industry, all playing a role to amplify consistent information and programs that reduce alcohol-related harm
- ongoing monitoring of the impacts of harmful alcohol consumption and programs designed to reduce harms.

⁶ <https://drinkwise.org.au/drinking-and-you/the-importance-of-moderation-during-covid-19/#>

⁷ <https://drinkwise.org.au/our-work/you-got-this-supporting-2020-school-leavers/#>

⁸ <https://drinkwise.org.au/our-work/bounce-back-podcast-presented-by-drinkwise/#>

Dutch Institute for Alcohol Policy STAP

Country/Location: Netherlands

URL: www.stap.nl

Submission

see attachment

Attachment(s): 1

00527_36_comments-stap-regarding-global-alcohol-strategy-of-the-who.pdf

Utrecht, 14-12-2020

Comments draft Global Action Plan WHO

ACTC

In the first place, it seems important that, following the FCTC, more explicitly is advocated for a comparable framework for alcohol. If that is achieved, it will mean a huge breakthrough for the development of effective global and national alcohol policy.

The past three years in the Netherlands have shown that without ACAC we will not get much further. Millions have again been invested in research and campaigns that the alcohol industry has had a say in, confirming ineffective policies. An ACAC will also support health ministers who usually lose out to employment and economic ministers in terms of power.

Cost of advertising exposure figures

A second point concerns the need for industry to be open about data regarding the exposure of alcohol advertising and sponsorship. It is now hardly impossible for NGOs to retain the concrete exposure data of alcohol advertising, especially with regard to young people. The costs for this are relatively high and the NGOs have, without extra governmental funding no budget for this. Moreover, these figures are sometimes literally unattainable for NGOs. We have dealt in the past with marketing agencies such as Nielsen flatly refusing to make data on the reach of alcohol advertising available to NGOs. It is my understanding that the reach of alcohol advertising in the US is publicly available based on legal obligations.

Non-alcoholic promotion

A third point concerns the advance of alcohol-free or low-alcohol products that are promoted with brand names, logos and appearance that are identical to those of alcoholic products. This means that advertising regulations for alcoholic beverages can be circumvented, which is now literally happening in Lithuania (one of the few countries with a ban). Brand names of alcohol products can be freely promoted even where strict regulations are in place. In other words the policy advice should be that advertising regulations cover not only alcoholic products per se, but also the brand names of alcoholic products.

Order online

Finally, even more emphasis should be placed on the fact that the advice regarding alcohol advertising also applies to advertising for online ordering and delivery of alcoholic beverages. Regarding the promotion of online ordering and delivery of alcohol: this will take off in the very near future and the regulations that are necessary for this will have to anticipate this.



Wim van Dalen
Director STAP

EASL

Department/Unit: *Policy and Public Health*

Country/Location: Switzerland

URL: <https://easl.eu/news/>

Submission

Main topics:

- Enhancing national/regional level capacities
- Targets and indicators
- National alcohol program and effective measures
- Marketing regulation of advertising and sponsorship of alcohol products
- Target the areas of government with competency to change policy
- Synergies at the clinical, behavioral and policy level

Attachment(s): 1

00338_15_easl-response-to-the-who-consultation.pdf

EASL response to the WHO Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Geneva, 11 December 2020

The European Association for the Study of the Liver (EASL) would like to thank the World Health Organization (WHO) for the opportunity to give our feedback to the WHO '*Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce Harmful Use of Alcohol*'.

EASL supports the efforts for achieving the implementation of the Global Strategy to reduce harmful use of alcohol from 2010 and would like to underline the following points:

Enhancing national/regional level capacities

The Strategy to Reduce the Harmful Use of Alcohol should introduce actions aiming to promote the implement a national alcohol strategy including rules on the commercialization and consumption of alcohol products, covering pricing, labelling, and advertising. It is important also to promote the dialogues, sharing of best practices not only within the Member States but also among and with the civil society. WHO regional offices could be a motor for such interactions and national/regional level.

Targets and indicators

The current WHO targets centre around alcohol consumption and not harm. This is based on the theory that population level alcohol consumption is directly correlated to alcohol related harm, and policies that impact on consumption this will reduce alcohol related harm.

First, this is problematic because it sends the wrong message that policies are anti-alcohol and not anti-alcohol related harm, this is a gift to the 'nanny state' neo liberal agenda.

Second, it is problematic because many of the interventions justified on this basis have nothing to do with population level consumption. For example, controls on exposure of children to alcohol marketing.

Third, even those controls that will impact on population level consumption have a far more targeted impact on harm. For example, MUP passed its various legal challenges purely because it is exquisitely targeted at consumers of the cheapest alcohol, namely heavy daily drinkers and minors.

However, it is possible to use harm metrics that are entirely alcohol attributable for example ICD 10 F10 which includes alcohol dependency and K70 alcohol related liver disease – liver disease is now second only to ischaemic heart disease as the leading cause of potential years of working life lost in the WHO

European area. Consideration should be given to switching to metrics that are more directly related to harms.

National alcohol program and effective measures

In 'Setting the scene', the document refers to the development of written national alcohol policies: EASL suggests a National Alcohol Program to be implemented in each EU country that should include the effective measures and these measures are common by and large to both alcohol and tobacco:

- Increase the price of alcohol through increases in excise taxes and other pricing policies.
- Consider a minimum price per alcohol gram, such that the minimum price of sale of an alcohol product (C) is calculated by multiplying the minimum price for alcohol per gram (A) with the amount in grams of the alcohol product (B): $A \times B = C$. As an example in Scotland this price was set on 50 pence, but it can be different in each country.
- Excise taxes and minimum unit price should be regularly reviewed and revised upwards appropriately according to inflation and the observed effects on the rate of alcohol consumption and alcohol-related harms.

Marketing regulation of advertising and sponsorship of alcohol products

Effective legislation to protect children and young people from the deleterious effects of alcohol marketing, good examples being France, Estonia, the Nordic Countries, Lithuania, including:

- Regulating sponsorship activities that promote alcoholic beverages
- Restricting or banning promotions in connection with activities targeting young people
- Regulating new forms of alcohol marketing techniques, for instance social media

The above should be monitored by public health bodies who will uphold consistent enforcement and accountability. Self-regulation by the alcohol industry is not an appropriate tool to address alcohol marketing.

The WHO has done some excellent preliminary work on digital marketing, but this program has not received the recognition it deserves and should be prioritised.

Target the areas of government with competency to change policy

Alcohol policy is generally seen to be a competency of Departments of Health or Public Health bodies, whereas the competency to change taxation lies with Treasuries, and the competency to change marketing regulations in another area of Government.

Much more effort could be made to communicate directly with the parts of government with the power to make the most effective changes. The work done by the smoke free partnership is an example of how much can be used with this approach.

Synergies at the clinical, behavioral and policy level

Currently, the commercial determinants of health (alcohol, poor diet etc) are the leading causes of ill-health, disability and death (2). These non-communicable disease policy areas are typically dealt with in silos, despite occurring together in clusters in the societies in which people live. There are behavioural, clinical and policy synergies. Behaviourally, 30% of heavy drinkers are obese and 30% of obese people are heavy drinkers in the UK and similar behavioural interactions occur between drinking and smoking. Clinically, drinking and smoking are multiplicative not additive risks for oropharyngeal cancers and obesity and alcohol are multiplicative risks for liver toxicity – a body mass index of >35 doubles the incidence of cirrhosis at any given alcohol intake (3). The most effective and cost-effective policies for tobacco (price and marketing) are also the most effective and cost-effective policies for alcohol and are likely to prove the most effective and cost-effective for obesity when the data accumulates. It does not make sense to duplicate effort and work in single health/policy areas given these strong behavioural, clinical and policy synergies.



The European Association for the Study of the Liver mission aims to be the Home of Hepatology so that all who are involved with treating liver disease can realise their full potential to cure and prevent it. The purpose of the association is to promote communication between European workers interested in the liver and its disorders. In particular, the association strives to:

- *Promote research concerning the liver*
- *Promote education of physicians, scientists, and public awareness of liver diseases and their management*
- *Act as an advisor to European and national health authorities concerning liver diseases, provision of clinical services and the need for research funding*
- *Foster European multicentre controlled trials*
- *Facilitate scientific exchange*
- *Facilitate the participation of Young Investigators at its meetings*

Contact details:

EASL Office:

Yoanna Nedelcheva Yoanna.nedelcheva@esloffice.eu

European Association for the Study of the Liver

7 rue Daubin 1203 Geneva Switzerland | Phone +41 22 807 03 60
esloffice@esloffice.eu | www.easl.eu

Educ'alcool

Country/Location: Canada

URL: www.educalcool.qc.ca

Submission

Neither trivialize, nor demonize.

Presentation

Éduc'alcool is a non-governmental, independent, not-for-profit organization founded 30 years ago. Its mission is to inform Quebecers adequately in order for them to make informed decisions about drinking, to encourage moderation for those who choose to drink alcohol and to take action to influence drinking contexts. The organization promotes the culture of moderation as opposed to the culture of excess. Its ultimate aim is to improve Quebec consumers' relationship to alcohol.

The objectives of Éduc'alcool are as follows:

- To educate the public in general and young people in particular with regard to drinking.
- To provide information on the psychological and physiological effects of alcohol.
- To prevent and denounce alcohol abuse and its consequences.
- To promote moderation in drinking.
- To debunk myths about alcohol and drinking.
- To intervene in order to influence drinking contexts
- To conduct and support social and scientific research.
- To examine the historical and cultural context of drinking.

Last October was the month for celebrating Éduc'alcool's 30th anniversary. We made the most of it, feeling pride and joy as we noted the progress Quebecers have made regarding their relationship to alcohol. But it was not a time of complacency, and we also looked ahead, contemplating all that remains to be done.

Introduction

Let's set the record straight without making any detours: alcohol is not tobacco.

Unlike the latter substance, there is a low-risk level of consumption of alcohol.

All well conducted studies have consistently proven it, especially in Western populations, and WHO should not give any credit to the ideologues that are trying to demonize alcohol and make people believe it is dangerous, no matter how or how much you drink.

Alcohol is no ordinary commodity, no question about that. Yet alcohol is no evil either. And if it is true that 3 million people die every year as a result of harmful use of alcohol; it is also true that 3 billion people enjoy the pleasure of drinking and don't experience any harm.

Hence, the debate about alcohol must be based on clarity, balance, and strict science, not on ideology and morality. It is WHO's responsibility to make sure that happens with this consultation.

Our contribution and thoughts

Educ'Alcool is hereafter submitting its comments and suggestions regarding WHO's working document for the development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol.

The WHO consultation on the Global Strategy to reduce the harmful use of alcohol is more than welcome as it gives us the opportunity to say clearly that it is about time that we collectively get out of the Manichean scheme that has too often been the rule in the discussions about this product.

And hence, allow us also to express our concern about what seems to us as a shift in WHO's approach in the field of alcohol, which has, to date, always been balanced and consensual. The Action Plan proposes a proscriptive approach in the form of SAFER/regulation enforcements, which is a significant departure from the usually flexible approach of offering member states the opportunity to call upon their own reality, their own context and their common sense when choosing which policies outlined in the Global strategy itself are deemed relevant to their own jurisdictions.

1.- About relativity

Our first remark is almost a warning. The World Health Organization must cover the whole planet and its action plans must be applicable on all continents and in all countries. Yet, we must all keep in mind that there are many contexts, many cultures, many legislations, many situations in the world and no action plan can limit itself to a sweeping statement with "one-size-fits-all" measures.

2.- About excesses

We would also want to invite WHO to avoid excesses. Even in the matter of action plans, moderation is always in good taste. As an example, WHO is consulting about the possibility of banning alcohol advertising. To this, our answer is simply: no. Alcohol advertising should undoubtedly be strictly harnessed. But just banning it would imply that alcohol is a harmful product per se, at all levels and patterns of consumption, that it does not have a low-risk level of consumption, that every glass of alcohol is harmful and that alcohol is treated like tobacco. It is scientifically wrong and a political mistake. We invite WHO to take the reality into account and not adopt a theoretical moralistic approach.

3.- About the action plan's goal

The action plan's goal is to reduce harmful use of alcohol. We know, as a matter of fact, that all drinkers don't experience harms, only a minority does, and therefore, the main focus of the measures should target those who derive harm from their alcohol consumption, rather than seek to eliminate alcohol use altogether. Policy should affect moderate healthy drinkers to a minimum, in order not to deprive them of the psychological and possibly physical benefits they may derive from their alcohol use.

This is not an easy task, but evaluations of policy implementation should be able to distinguish effects on harmful use of alcohol from effects on moderate drinkers; and alcohol per capita consumption - alone - simply does not allow that. The population approach may be easier but it is not accurate enough.

Although not ideal, an improved alternative would be to consider alcohol consumption per drinker, which would be based on the prevalence of drinkers in a given jurisdiction rather than the whole population.

4.- About advertising and marketing

In some countries, advertising is a real free-for-all and, naturally, it should be harnessed. But in many others, including ours, it is already very strictly regulated and therefore a recommendation to increase control in advertising would be unnecessary.

We would like to commend the proposed actions to regulate advertising and marketing, particularly to young and at-risk populations, as well as the regular monitoring of alcohol use and harms, particularly when monitored at a granular level of risk rather than at the general population.

5.- About an inclusive approach

Éduc'alcool is convinced, by experience, that the best results come from inclusive approaches where every player brings their own contribution and not via exclusions and anathema. Hence, we are questioning the general discourse about the alcohol industry across the working document as it seems totally excluded from any initiative.

Although it is undisputable that public health and industry goals diverge widely, a common ground could be found on certain topics (e.g., standard drinks and content labelling).

Considering their central role in the development of alcohol-related harm, it would make sense to seek their collaboration rather than adopting an oppositional stance, which may lead to an endless cat-and-mouse game.

As an example, the diagram that can be seen in our pdf. attachment also illustrates how industry funding could be put to good use. With a group of academics committed to serving public health goals acting as a firewall between industry funding and scientific research, industry funds could be used to respond to both its own interests and the public good.

6. – About pricing policies

The simple idea of increasing the price of alcohol could well make sense in countries where it is available at very cheap prices. Yet it is absolutely unthinkable, counterproductive and even ridiculous, to tell Sweden or Québec, that they should increase the price of alcohol.

In line with our recommendation to avoid one-size-fits-all approaches, we believe that member states would be more receptive to the WHO proposed actions if they could provide flexibility to individual member states' realities. For example, in countries where alcohol prices are already high, increasing prices through taxation could limit availability even to moderate drinkers, making high quality beverages even less accessible. On the other hand, focusing on a price-floor (also called minimum unit pricing)

would reduce consumption by those most at-risk of abusing alcohol, with minimal consequences on moderate drinkers who value taste and quality.

7. – About tracking progress

The working document suggests tracking progress by measuring the implementation of SAFER policy options. Although we agree with these measures, many other relevant progress indicators exist. For example, the percentage of the general population who is aware of alcohol effects at all consumption levels, or the percentage of the population who respects low-risk drinking guidelines.

8. – About having a “World no alcohol day”

We have absolutely no issue with having a “World no alcohol day”, or even a “World no alcohol week”, as long as the remaining 364 days or 51 weeks are considered as “Moderation days”.

As a conclusion

The Global Alcohol Strategy to reduce the harmful effects of alcohol has done a lot to raise the issue of alcohol high on the public debate agenda. Initiatives have been taken everywhere and the situation is improving on many issues even if the job is not, and will never be, done.

We know, everyone knows, that lasting progress results only when everyone gets involved, and a whole constellation of measures is implemented to achieve our common objectives.

We hence invite WHO to adopt an inclusive approach to tackling alcohol-related harms, and make sure all those who can play a role and do their fair share are welcome to bring their contributions because, to put it simply: “alone we go faster, together we go further”.

Alcohol per se is neither good nor bad. It’s what we do with it that makes a difference. It should certainly not be trivialized, nor should it be demon

Attachment(s): 1

00209_27_2020-12-03-educ-alcohol-consultation-oms.pdf



*Éduc'alcool's contribution to WHO's consultation
on the Working document for development
of an action plan to strengthen implementation
of the Global Strategy to Reduce the Harmful Use of Alcohol*

Neither trivialize,
nor demonize.

Presentation

Éduc'alcool is a non-governmental, independent, not-for-profit organization founded 30 years ago. Its mission is to inform Quebecers adequately in order for them to make informed decisions about drinking, to encourage moderation for those who choose to drink alcohol and to take action to influence drinking contexts. The organization promotes the culture of moderation as opposed to the culture of excess. Its ultimate aim is to improve Quebec consumers' relationship to alcohol.

The objectives of Éduc'alcool are as follows:

- To educate the public in general and young people in particular with regard to drinking.
- To provide information on the psychological and physiological effects of alcohol.
- To prevent and denounce alcohol abuse and its consequences.
- To promote moderation in drinking.
- To debunk myths about alcohol and drinking.
- To intervene in order to influence drinking contexts
- To conduct and support social and scientific research.
- To examine the historical and cultural context of drinking.

Last October was the month for celebrating Éduc'alcool's 30th anniversary. We made the most of it, feeling pride and joy as we noted the progress Quebecers have made regarding their relationship to alcohol. But it was not a time of complacency, and we also looked ahead, contemplating all that remains to be done.

Introduction

Let's set the record straight without making any detours: alcohol is not tobacco.

Unlike the latter substance, there is a low-risk level of consumption of alcohol.

All well conducted studies have consistently proven it, especially in Western populations, and WHO should not give any credit to the ideologues that are trying to demonize alcohol and make people believe it is dangerous, no matter how or how much you drink.

Alcohol is no ordinary commodity, no question about that. Yet alcohol is no evil either. And if it is true that 3 million people die every year as a result of harmful use of alcohol; it is also true that 3 billion people enjoy the pleasure of drinking and don't experience any harm.

Hence, the debate about alcohol must be based on clarity, balance, and strict science, not on ideology and morality. It is WHO's responsibility to make sure that happens with this consultation.

Our contribution and thoughts

Educ'alcool is hereafter submitting its comments and suggestions regarding WHO's working document for the development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol.

The WHO consultation on the Global Strategy to reduce the harmful use of alcohol is more than welcome as it gives us the opportunity to say clearly that it is about time that we collectively get out of the Manichean scheme that has too often been the rule in the discussions about this product.

And hence, allow us also to express our concern about what seems to us as a shift in WHO's approach in the field of alcohol, which has, to date, always been balanced and consensual. The Action Plan proposes a proscriptive approach in the form of SAFER/regulation enforcements, which is a significant departure from the usually flexible approach of offering member states the opportunity to call upon their own reality, their own context and their common sense when choosing which policies outlined in the Global strategy itself are deemed relevant to their own jurisdictions.

1.- About relativity

Our first remark is almost a warning. The World Health Organization must cover the whole planet and its action plans must be applicable on all continents and in all countries. Yet, we must all keep in mind that there are many contexts, many cultures, many legislations, many situations in the world and no action plan can limit itself to a sweeping statement with "one-size-fits-all" measures.

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3.- About the action plan's goal

The action plan's goal is to reduce harmful use of alcohol. We know, as a matter of fact, that all drinkers don't experience harms, only a minority does, and therefore,

the main focus of the measures should target those who derive harm from their alcohol consumption, rather than seek to eliminate alcohol use altogether. Policy should affect moderate healthy drinkers to a minimum, in order not to deprive them of the psychological and possibly physical benefits they may derive from their alcohol use.

This is not an easy task, but evaluations of policy implementation should be able to distinguish effects on harmful use of alcohol from effects on moderate drinkers; and alcohol per capita consumption - alone - simply does not allow that. The population approach may be easier but it is not accurate enough.

Although not ideal, an improved alternative would be to consider alcohol consumption per drinker, which would be based on the prevalence of drinkers in a given jurisdiction rather than the whole population.

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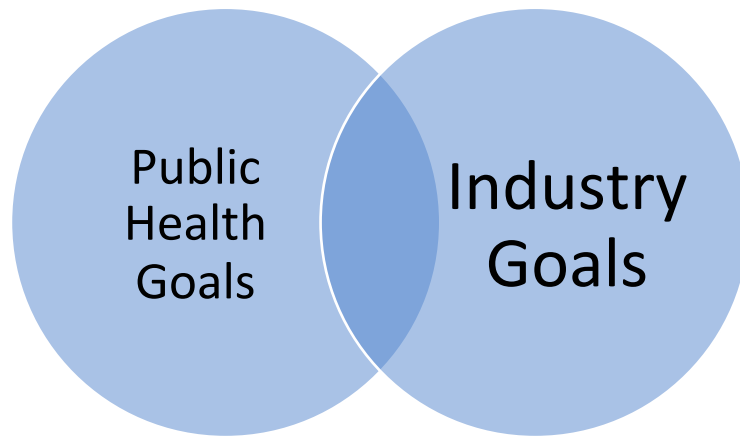
We would like to commend the proposed actions to regulate advertising and marketing, particularly to young and at-risk populations, as well as the regular monitoring of alcohol use and harms, particularly when monitored at a granular level of risk rather than at the general population.

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Éduc'alcool is convinced, by experience, that the best results come from inclusive approaches where every player brings their own contribution and not via exclusions and anathema. Hence, we are questioning the general discourse about the alcohol industry across the working document as it seems totally excluded from any initiative.

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Considering their central role in the development of alcohol-related harm, it would make sense to seek their collaboration rather than adopting an oppositional stance, which may lead to an endless cat-and-mouse game.



As an example, the above diagram also illustrates how industry funding could be put to good use. With a group of academics committed to serving public health goals acting as a firewall between industry funding and scientific research, industry funds could be used to respond to both its own interests and the public good.

6. – About pricing policies

The simple idea of increasing the price of alcohol could well make sense in countries where it is available at very cheap prices. Yet it is absolutely unthinkable, counterproductive and even ridiculous, to tell Sweden or Québec, that they should increase the price of alcohol.

In line with our recommendation to avoid one-size-fits-all approaches, we believe that member states would be more receptive to the WHO proposed actions if they could provide flexibility to individual member states' realities. For example, in countries where alcohol prices are already high, increasing prices through taxation could limit availability even to moderate drinkers, making high quality beverages even less accessible. On the other hand, focusing on a price-floor (also called minimum unit pricing) would reduce consumption by those most at-risk of abusing alcohol, with minimal consequences on moderate drinkers who value taste and quality.

7. – About tracking progress

The working document suggests tracking progress by measuring the implementation of SAFER policy options. Although we agree with these measures, many other relevant progress indicators exist. For example, the percentage of the general population who is aware of alcohol effects at all consumption levels, or the percentage of the population who respects low-risk drinking guidelines.

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The Global Alcohol Strategy to reduce the harmful effects of alcohol has done a lot to raise the issue of alcohol high on the public debate agenda. Initiatives have been taken everywhere and the situation is improving on many issues even if the job is not, and will never be, done.

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Epicenter

Country/Location: Belgium

URL: <http://www.epicenternetwork.eu/>

Submission

The WHO action plan has logical, technical, and procedural deficiencies. First, reducing the average alcohol consumption per capita does not necessarily lead to a reduction in alcohol-related harm because excessive drinkers typically consume a disproportionate amount of alcohol. Furthermore, evidence suggests that the neo-prohibitionist policies proposed to tackle the problem of the harmful use of alcohol are ineffective at best and counterproductive at worst. Finally, the outlined strategy to achieve WHO's policy goals seems to be unrealistic and cost inefficient. Smart regulations and more targeted policies, rather than measures imposed upon society as a whole, seem to be more appropriate and socially beneficial.

Attachment(s): 1

00361_30_neo-prohibitionism-does-not-mitigate-alcohol-related-health-risks.pdf

Neo-prohibitionism does not mitigate alcohol related health risks

Introduction

The WHO Executive Board has recently called for a concerted and accelerated policy action to reduce the harmful use of alcohol. More specifically, the Board has requested to develop an action plan to [strengthen the implementation](#) of the [Global Strategy](#) to Reduce the Harmful Use of Alcohol. The purpose of and the vision behind such a plan are exposed in the official working document released on 14th November 2020.

The rationale behind the Action Plan

The Alcohol Policy advocated in the action plan aims to reduce per capita alcohol consumption in order to mitigate the harmful effects of alcohol. The underlying assumption of the plan seems to be that alcohol use statistically correlates with alcohol-related harm. Reducing the average alcohol consumption through broad measures like excise taxes and advertising bans would allegedly reduce the level of harm. However, this assumption has proven to be [debatable](#) both empirically and theoretically. The key fact is that a small percentage of drinkers [consume](#) a disproportionate amount of alcohol. For instance, in the US the top 10 percent of drinkers consume almost 60 percent of alcohol. As a result, smart regulations and focused policies targeting excessive drinkers are likely to be more effective than broad measures “punishing” the majority.

Policy Recommendations by the WHO

The overarching goal of the action plan is the reduction of the morbidity and mortality as a consequence of alcohol consumption. Six key areas are identified: (1) implementation of high-impact strategies and interventions; (2) advocacy, awareness and commitment; (3) partnership, dialogue and coordination; (4) technical support and capacity building; (5) knowledge production and information systems; (6) Resource mobilisation.

The first key area, as the name suggests, sets the policy priorities and aims to implement a range of cost-effective policy options. [SAFER](#), the WHO-led initiative to help governments better deal with alcohol-related health issues, has suggested to strengthen restrictions on alcohol availability, banning alcohol advertising, and increase alcoholic beverages’ prices through excise taxes. All these measures share a clear neo-prohibitionist flavour. More importantly, their effectiveness is highly controversial.

First, excise taxes and other similar pricing policies are typically [regressive](#), which means that low-income earners bear the tax burden proportionally higher than they high-income counterparts. [Studies](#) show that in Britain moderate drinkers in the bottom fifth of households spend 2 to 4 percent of their income in alcohol taxes. The poorest income group spends, as a proportion of their income, twice as much on sin taxes as the richer income group. Furthermore, increased taxes cause a deadweight loss in the market, that is, an overall economic loss due to unexploited exchange opportunities.

Second, [there is no evidence](#) that restricting or banning alcohol advertising has any meaningful effect on consumers’ behaviour. [It is also doubtful](#) that a correlation exists between lifting alcohol ad bans and an increase in alcohol consumption. Importantly, advertising bans have of course a detrimental impact on the economic freedom of both buyers and sellers.

Third, historical evidence suggests that imposing restrictions on alcohol availability is a [recipe for failure](#), as it lowers the quality of the products sold and increases the size of black markets.

The other key areas revolve around the first one. More specifically, they aim at maximising the effectiveness of the aforementioned set of policies by (2) raising awareness on alcohol-related harm, (3) increasing the coordination between health and non-health sectors to implement multisectoral measures, (4) creating and developing the necessary decision-making frameworks and infrastructures, (5) facilitating the evaluation of public health policies, and (6) overcoming the problem of lack of resources to carry on effective policies.

These proposals suffer from a several weaknesses. First, they are not targeted, these measures are too broad to be efficient. They purport to address the problem of harmful alcohol use from a variety of angles at the same time. Coordinating an effective multisectoral action, while restructuring institutions and healthcare systems, and implementing the policies mentioned above could turn out to be simply too costly to be justified. Therefore, a more targeted and cost-efficient approach seems to be warranted.

Conclusion

The WHO action plan has logical, technical, and procedural deficiencies. First, reducing the average alcohol consumption per capita does not necessarily lead to a reduction in alcohol-related harm because excessive drinkers typically consume a disproportionate amount of alcohol. Furthermore, evidence suggests that the neo-prohibitionist policies proposed to tackle the problem of the harmful use of alcohol are ineffective at best and counterproductive at worst. Finally, the outlined strategy to achieve WHO's policy goals seems to be unrealistic and cost inefficient. Smart regulations and more targeted policies, rather than measures imposed upon society as a whole, seem to be more appropriate and socially beneficial.

European Alcohol Policy Alliance - Eurocare

Country/Location: Belgium

URL: www.eurocare.org

Submission

The European Alcohol Policy Alliance (Eurocare) would like to thank World Health Organization (WHO) for the opportunity to give our feedback to the WHO 'Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce Harmful Use of Alcohol'. We believe the draft is a positive step forward for achieving the implementation of the Global Strategy to reduce harmful use of alcohol from 2010. However, we present several suggestions and comments in the attachment. Some of the key points in our response are: (1) the need to include regional levels for an effective and appropriate implementation of the global strategy (2) proportionate universalism - Eurocare would like to stress the need for the implementation of the WHO Best Buys which have a particular impact on high risk situations and populations such as heavy drinking occasions and people affected by alcohol use disorder, but also affect alcohol consumption and harm more generally. (3) Accountability and transparency: Eurocare believe that the issue of accountability should be better reflected in the working document. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the action plan. In addition, Eurocare would suggest a transparency register, a database of special interest groups whose goal is to influence policy to be set up by WHO. (4) Role of economic operators.

Attachment(s): 1

00354_24_6.12-eurocare-consultation-response-to-who-global-action-plan.pdf

**Submission to WHO Working document for development of an action plan to
strengthen implementation of the Global Strategy to Reduce the Harmful
Use of Alcohol**

For the attention of

Dr Vladimir Poznyak

Unit Head – Alcohol, drugs and addictive behaviours

World Health Organization



December 2020



The European Alcohol Policy Alliance (EUROCARE)

The European Alcohol Policy Alliance (EUROCARE) is an alliance of non-governmental and public health organisations with around 54 member organisations across 22 European countries advocating the prevention and reduction of alcohol related harm in Europe. Member organisations are involved in advocacy and research, as well as in the provision of information and training on alcohol issues and the service for people whose lives are affected by alcohol problems.

The mission of Eurocare is to promote policies to prevent and reduce alcohol related harm. The message, regarding alcohol consumption is “**less is better**”.

Eurocare is not affiliated and does not receive any funding from the alcohol industry or any of its social aspect organizations.

Eurocare is registered in the European Transparency Register under number: 01546986656-22.

Eurocare’s introductory remarks

The European Alcohol Policy Alliance (Eurocare) would like to thank World Health Organization (WHO) for the opportunity to give our feedback to the WHO ‘Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce Harmful Use of Alcohol’.

This is a positive step forward for achieving the implementation of the Global Strategy to reduce harmful use of alcohol from 2010.

Eurocare is an accredited civil society organization to WHO Europe and look forward to supporting the WHO Global Action Plan.

Regional level needs to be included

There is no clear reference or actions directed to neither a regional political body, such as the European Union nor the WHO regional offices.

As a European civil society umbrella organization, we experience the need and value of addressing alcohol policy at a regional level. Cross border policy areas like trade, taxation, labelling, and marketing are examples of policy areas that needs a regional/international approach. In a European context it has been valuable to discuss these areas in addition to capacity building and knowledge sharing of best practice – both between and among Member States and civil society.

WHO regional offices are important for technical support to Member States in areas like following trends in alcohol consumption, estimates of alcohol harm, and financial costs.

Eurocare would therefore propose addressing the role of the Regional levels and offices in a final version of the action plan.

Enforcement of a written policy

In ‘Setting the scene’, the document refers to the development of written national alcohol policies: ‘However, the presence of written national alcohol policies continues to be most common in high-income countries and least common among low-income countries’.

Eurocare would like to highlight the importance of enforcement and implementation of the policy documents, and not only that they are written. We therefore welcome Global Target 1.1 ‘By 2030, 75% of countries have introduced and/or strengthened and sustainably enforced implementation of high-

impact policy options and interventions. However, we suggest streamlining target 1.1 and 1.3, and suggest that the target will be 80 % in both targets.

Proportionate universalism

The working document points out that ‘A significant proportion of alcoholic beverages is consumed in heavy drinking occasions and by people affected by AUD, illustrating the inherent contradiction between the interests of alcohol producers and public health.’

Eurocare would like to stress the need for the implementation of the WHO Best Buys which have a particular impact on high risk situations and populations such as heavy drinking occasions and people affected by alcohol use disorder, but also affect alcohol consumption and harm more generally.

Eurocare see additional policies, such as brief interventions and treatment, as complementary policies to the prevention effects of the WHO Best Buys. These interventions with individuals work alongside the WHO Best Buys. They are not a replacement for them. The working document should describe the synergistic relationship between prevention and intervention policies more strongly.

Accountability and transparency

Eurocare believe that the issue of accountability should be better reflected in the working document. How will reporting and publishing of the reporting take place?

We are concerned about the lack of specific time intervals for review and reporting of the implementation of the action plan. Given the importance of intergovernmental collaboration to reduce alcohol harm, Eurocare would like to echo GAPA’s recommendation that the Director General be requested to report to the WHA biennially on the progress of implementing the Global Action Plan including any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Furthermore, the numerous and sometimes overlapping recommendations in the draft document tend to obscure a focus on the most cost-effective policies to reduce alcohol-related harms. The Action Plan should be strongly framed around every country implementing the five most effective, science-based interventions, as articulated in the SAFER guidance.

WHO’s decision-making process should be as transparent and open as possible. The more open the process is, the easier it is to ensure balanced representation and avoid undue pressure and illegitimate or privileged access to information or to decision-makers.

Eurocare would suggest a transparency register, a database of special interest groups whose goal is to influence policy to be set up by WHO. The register makes visible what interests are being pursued, by whom and with what budgets. In this way, the register allows for public scrutiny, giving citizens and other interest groups the possibility to track the activities of lobbyists. WHO officials should publish information on meetings held with organisations or self-employed individuals. Meetings relating to policymaking and implementation should only take place if the interest representative are registered in the WHO transparency register. Minutes from all meetings should be published.

Role of economic operators

In the current document the “economic operators” – i.e., alcohol industry entities (producers, distributors, retailers, etc) are listed as stakeholders in equal standing alongside civil society and other UN organizations. This is inappropriate, given their inherent conflict of interest and long record of influence against effective alcohol policies, including in low- and middle-income countries (LMIC). The alcohol industry should, instead, be addressed in a separate section with due regard to conflict of

interest toward safeguarding public health. Please also see above the suggestion for a transparency register.

Exposure, not target group, of marketing and advertisement

Marketing, and particularly advertisement, is an issue Eurocare has been following for years at the EU level, in relation to e.g. the EU Audiovisual Media Services Directive (EU AVMSD). Based on this experience, Eurocare would like to suggest changing the language from 'targeted' in relation to commercial activities, to 'exposure'. This would follow the recent developments at EU level.

The issue in relation to the groups identified in the working document is the exposure of advertisement, and not whether they were a target group or not. We therefore suggest changing this at least in the following two places in the working document:

Scope of the action plan, page 6: *'Alcohol marketing, advertising and promotional activities of alcoholic beverages are of deep concern, including those implemented through cross-border marketing, and targeting young people and adolescents'*

Action Area 1, Action 3 Proposed actions for international partners and non-State actors, page 22: *'Economic operators in alcohol production and trade, as well as economic operators in other relevant sectors (such as retail, advertisements, social media and communication), are encouraged to contribute to the elimination of marketing and sales of alcoholic beverages to minors and targeted commercial activities towards other high-risk groups.'*

Opportunities for reducing the harmful use of alcohol

Harmful and hazardous alcohol consumption has a major impact on public health and also generates costs related to health care, health insurance, law enforcement and public order, and workplaces, and thus has a negative impact on economic development and on society as a whole. There are several areas for concern that Eurocare would like to raise as:

-)] Exposure to alcohol during pregnancy can impair brain development of the fetus and is associated with intellectual deficits that become apparent later in childhood. It is imperative to reduce exposure to alcohol during pregnancy, thereby reducing the number of children born with Fetal Alcohol Disorders.
-)] Young people are particularly at risk and are disproportionately affected by alcohol. While 5,5% of all deaths in a population are alcohol attributable for the age group 15-19 this is 19% and for the age group 20-24 it is even higher reaching 23,3%.
-)] Traffic accidents related to alcohol consumption are a major cause for concern. About one accident in four in EU can be linked to alcohol consumption and at least 10.000 people are killed in alcohol-related road accidents in the EU each year.
-)] Alcohol is addictive and WHO Action Plan should generate knowledge and capacity building in how to best help individuals in society, communities and their families and prevent relapse.

International legal instrument

Eurocare support the understanding that alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally binding regulatory instruments. This needs to be addressed at an intergovernmental level. Cross border issues are hard to tackle as one Member State alone, which calls for a regional or global approach to these policies.

Contact details

For more information please contact:

Nils Garnes

European Alcohol Policy Alliance

Rue Archimede 17

1000 Brussels, Belgium

E-mail : Nils.Garnes@eurocare.org/info@eurocare.org

European Commission

Department/Unit: *Health and Food Safety Directorate General (SANTE), International Relations Unit (C.4)*

Country/Location: Luxembourg

URL: <https://ec.europa.eu>

Submission

Referring to the WHO consultation on a working document for the development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol, I would like to ask you to consider the following comments from the European Commission:

The European Commission welcomes the proposal of WHO Alcohol action plan (2022- 2030).

We noted that implementation of the WHO alcohol plan partly overlaps with the implementation of the Europe's Beating Cancer Plan (to be adopted early 2021). Addressing the lifestyle related risk factors of cancer, including alcohol, will be an important part of prevention pillar of the Cancer plan.

We would therefore welcome closer cooperation with WHO on the issues of mutual interest, including the alcohol online marketing, supporting EU Member States in the implementation of specific actions against harmful alcohol consumption and on illicit alcohol.

In this context, we would recommend to highlight even more the necessary information/education actions to raise awareness on the impact of alcohol misuse on health, more specifically on the links between alcohol and cancer. Furthermore, we would welcome our mutual cooperation on data collection, research and monitoring of the progress in implementation.

Given the specificities of the Union, (national competencies versus EU competencies, free movements of goods ect.) we would welcome a more regional specific approach.

Starting from 2021, we would suggest to meet regularly at technical level to exchange information on progress in the implementation of the actions on alcohol foreseen by the EU Cancer Plan and WHO Action plan on alcohol.

European Fetal Alcohol Spectrum Disorders Alliance

Country/Location: Sweden

URL: www.eufasd.org

Submission

Please see the attachment. In summary:

Fetal Alcohol Spectrum Disorders should receive explicit mention as an example of alcohol-related harm.

Research is needed on the causes and effects of drinking with a focus on women.

Stigmatization should be avoided at all levels.

The alcohol industry should not be named as an international partner in prevention.

Attachment(s): 1

00390_43_comments-of-european-fetal-alcohol-spectrum-disorders-alliance.pdf



The European Fetal Alcohol Spectrum Disorders Alliance

The European Fetal Alcohol Spectrum Disorders Alliance was founded in February 2011 to meet the growing need for European professionals and NGOs concerned with FASD to share ideas and work together. Our goals are (1) to support the member associations in their efforts to improve the quality of life for all people with Fetal Alcohol Spectrum Disorders and their families and (2) to improve awareness of the risks of drinking alcoholic beverages during pregnancy. The Alliance currently comprises 38 member organizations in 20 countries of the WHO European region.

Introduction

We are very pleased that the WHO is working to improve implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. In particular, we find it useful to have specific actions outlined for various groups, including civil society organizations, and we look forward to working together with the WHO to reduce alcohol-related harm, especially Fetal Alcohol Spectrum Disorders.

Fetal Alcohol Spectrum Disorders should receive explicit mention

We realize that the focus of this document is on implementation of the Strategy. However we note that when examples of harms are given, Fetal Alcohol Spectrum Disorders are not mentioned at all. We emphasize that exposure to alcohol at any time during the pregnancy, even before the pregnancy is recognized, poses a risk to normal brain development of the fetus and that prenatal alcohol exposure may be associated with physical and intellectual deficits that appear only later in childhood. Prenatal exposure to alcohol is the leading cause worldwide of congenital cognitive impairment, and it is 100% preventable. No safe level has been or will be established for alcohol use during pregnancy, hence our advice is that the only safe amount of alcohol during the conception period and pregnancy is zero.

The draft document makes several mentions of cancer, cardiovascular disease, liver disease, and drink driving. Omission of Fetal Alcohol Spectrum Disorders is unfortunate because prenatal exposure to alcohol (1) causes lifelong damage and (2) predisposes the individual to early initiation of drinking and alcohol misuse, thus increasing the risk of all the other alcohol harms.

Throughout the WHO document, we note several opportunities to present this important public health problem, and make suggestions to improve the text.

1. Page 3, paragraph 2. Currently the last sentence is "Younger people..." We suggest adding another sentence "In addition, an estimated 14.6 persons per 10,000 suffer lifelong disabilities due to prenatal alcohol exposure."¹
2. Page 5, paragraph 5. Currently the second to last sentence reads, "One contributory factor is" then goes on to list some harms. We suggest adding Fetal Alcohol Spectrum Disorders to the list.
3. Page 6, paragraph 1. Currently the second to last sentence reads, "Increased alcohol consumption can exacerbate health and social inequalities between genders as well as social classes." We suggest adding "Prenatal exposure to alcohol contributes to lower educational levels and higher risk of unemployment, thus contributing to social inequalities."²
4. Page 13, Action Area 2: Advocacy, Awareness and Commitment, paragraph 2. Currently the second sentence recommends that "appropriate attention should be given to preventing the initiation of drinking among children and adolescents and protecting people from...." We suggest adding the phrase as in italics here "appropriate attention should be given to *protecting the unborn child from prenatal exposure*, preventing the initiation of drinking among children and adolescents and protecting people from...."
5. Page 19, Action Area 5: Knowledge Production and Information Systems, paragraph 2. The first sentence mentions "harm to others from drinking, on the impact of the harmful use of alcohol on child development and maternal health. . ." In fact, there is no safe use of alcohol in pregnancy--all use of alcohol in pregnancy is harmful. We suggest adding the phrase in italics here "harm to others from drinking, on the impact of any quantity of alcohol on *fetal development*, child development and maternal health. . ."

Research is needed on the causes and effects of drinking with a focus on women

6. Page 19, Action Area 5. It is important to understand why women, whether pregnant or not, engage or do not engage in drinking alcohol because this will inform development of effective health promotion programs. Preventing alcohol related harm requires more than just programs to increase awareness and knowledge, but requires evidence-based programs that are proven to modify the determinants of drinking, including in pregnancy, and change drinking behaviour. Currently too little is known about these determinants, leaving prevention workers without the tools to develop effective programs. Given the preventable nature of alcohol related harm, it is important that such guidelines become available.

¹ Popova S, Lange S, Probst C, Gmel G, Rehm J. Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis. *Lancet Glob Health*. 2017 Mar;5(3):e290-e299. doi: 10.1016/S2214-109X(17)30021-9. Epub 2017 Jan 13. Erratum in: *Lancet Glob Health*. 2017 Mar;5(3):e276. PMID: 28089487.

² Thanh NX, Jonsson E, Moffatt J, Dennett L. Fetal alcohol spectrum disorder--poverty trap? *J Popul Ther Clin Pharmacol*. 2013;20(1):e63-6. Epub 2013 Mar 4. PMID: 23458991.

Stigmatization should be avoided at all levels

Alcohol Use Disorder must be considered a medical condition and not a moral issue. This principle applies in particular to pregnant women and to their alcohol-affected offspring. Stigma extends to families raising these children and adults affected by FASD, as well as to professionals who serve them. These marginalized groups should receive respectful and non-stigmatizing support.

In this regard, we would like to comment on p13, paragraph 2. We suggest that the sentence beginning "Public health advocacy is more likely..." to "Public health advocacy must be developed using a systematic evidence-based approach that takes into account the important aspect of stigma."

The alcohol industry should not be named as an international partner in prevention

The alcohol industry is not a credible partner in preventing alcohol-related harm, so they should not be mentioned as such.

Concluding remarks

We look forward to working with the WHO to improve implementation of the Global Strategy.

With best regards,

Diane Black, Ph.D.; Oscar Garcia-Algar, M.D.; and Teodora Ciolompea, M.D.

for the Board of the European Fetal Alcohol Spectrum Disorders Alliance

Co-signed by the following



Simona Pichini
Analytical Pharmacotoxicology Unit Head
National Centre on Addiction and Doping
Istituto Superiore di Sanità
V.Le Regina Elena 299, 00161 Rome, Italy



European Mutual help Network for Alcohol related problems (EMNA)

Country/Location: Italy

Submission

After a short introduction about EMNA, the below attachment contains some suggestions for reducing the harm done by alcohol. In particular we support the three "best buys", plus we suggest some action in fields like comprehensive, well visible and self-explanatory labelling on containers, enforcement of the "harm to others" perspective, sensitizing medical professionals, recognizing the role and importance of community programs, such as that of mutual help groups, and finally, the invitation to WHO to appoint the various Alcohol Observatories and the National Collaborating Centers to put pressure on the respective Ministers of Health in order to achieve effective national legislations.

Attachment(s): 1

00224_35_who-consultation-2020-emna-contribution.pdf



The European Mutual Help Network for Alcohol Related Problems (EMNA)

EMNA is an alliance of 16 non-governmental organisations across 11 European countries, with the objective of promoting mutual help-groups and community programmes, as an important part of the treatment, enabling people with alcohol related problems to overcome dependency, to recover, to reintegrate within their family and community, and to prevent relapse. Often, the groups are offering their service not only to the people whose lives are affected by alcohol problems, but also extending it to their family members and relatives.

At European level, EMNA is trying to give a voice to people affected by the harm of alcohol. EMNA is also trying to strengthen the role of volunteers as a valuable resource, as complementary to professional treatment, as part of a comprehensive approach to alcohol related problems. Our mutual help groups are not in competition with Health Services, on the contrary, they promote dialogue with professionals, health officials, public authorities and the academic community. Finally, being actively engaged also in prevention policies, EMNA wants to raise awareness of the mutual help-approach and community programmes in all the member states of the European Union.

Alcohol plan 2022-2030

Priority actions for reducing alcohol consumption

We could not agree more on the “best buys” for reducing the harm done by alcohol. These include:

- 1) increase in excise taxes on alcoholic beverages
- 2) bans or comprehensive restrictions on exposure to alcohol advertising
- 3) restrictions on physical availability of alcohol through the reduction of hours of sales and of the density of retail points.

These measures need to be implemented by the Member States, and because they are highly cost-effective, the Governments don't have the excuse of budget difficulties.

However, these core areas for effective action should be complemented by other measures that we recommend.

Additional areas for action

Regarding information for prevention, it is intolerable that still today the consumers are not being advised about the possible health consequences of even a moderate use of alcohol, so it is time to ensure comprehensive, well visible and self-explanatory labelling across Europe, containing health warnings, plus nutritional and ingredients listing, and declaring the presence of allergens. Showing health warnings on labels has proven to be effective in reducing alcohol consumption in the general population (Tim Stockwell et al.), and in any case there is no reason why, among all edible products, only the alcoholic beverages should be exempted by such mandatory information, to the extent that the authorities who fail to secure this information could, in the future, be taken to court as responsible for the omission.

The need for better information expands to the "harm to others" perspective. This, according to authoritative studies (David Nutt et al.) outweighs the damage done to the individual drinker, so as to place alcohol on top of all drugs, as a whole. It is disconcerting that this information is not advertised and related, as it should be, to accidents at work, traffic accidents, domestic violence, rape, murder etc.

Regarding the need for WHO to work across professional fields, it must be taken in consideration the need to sensitize medical professionals, in particular from Cardiovascular Diseases (CVD) and cancer field, in raising awareness about the link between these conditions and alcohol consumption. Still too many doctors, in many countries, support the popular belief that a glass of wine is good for the heart, while they do not inform their patients about the potential harm of alcohol consumption.

Regarding facilitating access to screening, brief interventions, and treatment, WHO should recognize the role and importance of community programs, such as that of mutual help groups, made up of individuals and families who have alcohol-related problems and who take action to change their lifestyle and that of the community they belong to. This recognition must also be evaluated from the economic point of view, as these groups are generally for free and cost nothing to society, while they can alleviate the burden of morbidity caused by alcohol on public services. All this in

a public-private cooperation framework, that avoids competition and increases synergies.

Action is necessary at regional level

The WHO has rightly set the goal of informing its Assembly and the public opinion about the progress made in the implementation of the Strategy, but it is equally important that the actions are developed at a regional level, for example WHO could appoint the various Alcohol Observatories and the National Collaborating Centers to put pressure on the respective Ministers of Health of each individual nation, in order to arrive at effective national legislation, with the obligation for these Centers to report back to the WHO each year on the progress made.

Ennio Palmesino

EMNA European Officer, Genoa (Italy), e-mail ennio@palmesino.it

European Network of Teratology Information Services (ENTIS)

Country/Location: Israel

URL: <https://www.entis-org.eu/>

Submission

It is important to mention the risks of using alcohol during pregnancy, FASD, as an important harm that needs to be addressed.

Attachment(s): 0

European Public Health Alliance

Country/Location: Belgium

URL: <https://epha.org/>

Submission

The European Public Health Alliance (EPHA) values this opportunity to contribute to the working document for the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol (the strategy).

While in broad agreement with the working document, EPHA would like to add the following considerations to further strengthen it.

Our observations are organised under the following headings:

- 1) Extend recommendations towards regional governance structures, such as the European Union.
- 2) Prioritise the most effective measures.
- 3) Enhance synergies with other non-communicable disease prevention efforts.
- 4) Do not focus on targeting, but address the exposure to marketing and advertising.
- 5) Clarify the status of economic operators as being different from health civil society and introduce a transparency register.
- 6) Enhance measures for accountability and reporting

Attachment(s): 0

Fascinating children

Country/Location: Slovakia

URL: www.fascinujucedeti.sk

Submission

It is important to mention that alcohol during pregnancy as one of the harms which must be addressed.

Attachment(s): 0

FASD Network UK

Country/Location: United Kingdom of Great Britain and Northern Ireland

Submission

Prenatal alcohol exposure is blighting future generations from having the best start in life. This continues to be the leading cause of preventable learning disability and we look to the WHO to strengthen the protections of unborn children by addressing alcohol harm firmly.

Attachment(s): 1

00486_12_who-letter.pdf



FASD Network UK
Newtown Centre,
123 Durham Rd,
Stockton,
TS190DE
fasdnetwork@mail.com

13 December 2020

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organisation (WHO)
Avenue Appia 20 1211 Geneva

Dear Director-General,

Submission on the Working Document for the development of an Action Plan to strengthen implementation of the WHO Global Alcohol Strategy (Working Document)

We have reviewed the Working Document for the development of an action plan to strengthen implementation of the WHO Global Alcohol Strategy (WHO GAS) and have the following comments and suggestions for your consideration.

FASD Network UK exists to support families affected by prenatal alcohol exposure. Foetal Alcohol Spectrum Disorders is one of the leading causes of preventable learning disability and affects many thousands of residents in the UK.

Target 3.5 of the United Nations Sustainable Development Goals 2030 includes the objective of strengthening the prevention and treatment of substance abuse, including the harmful use of alcohol. The vision behind the *2010 Global Strategy to Reduce the Harmful Use of Alcohol* is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to alcohol and the ensuing social consequences.

We see poor outcomes for children prenatally alcohol exposed and long term outcomes result in more than 90% having mental health issues, two thirds failing in education, half becoming involved in criminal justice, a third going on to their own addictions and more than 70% failing to be employable and manage independent living well. Alcohol has massive costs on society and this isn't reflected in the WHO strategy.

An effective Action Plan is needed to strengthen the Global Strategy

The implementation of the Global Strategy has been uneven across the WHO regions. Between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita. Implementation of the alcohol policy best buy solutions has been insufficient in most countries around world over the last ten years. The alcohol industry has continued to interfere in alcohol policy-making processes. Therefore, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, alcohol caused three million deaths worldwide. Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. Without a clear Action Plan, the Global Strategy will remain unrealized and the health, social, economic and development harms of alcohol consumption will remain high and continue to be an obstacle to achieving the Sustainable Development Goals.

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan.

Strengths of the Action Plan include:

- The focus on the *'Implementation of High-Impact Strategies and Interventions'* or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.
- The inclusion of an objective focussing on prevention and treatment capacity being an integral part of universal health coverage.

There are also areas where the Action Plan can be strengthened, including:

- Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization
- Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm
- Dealing with the alcohol industry in a single paragraph due to their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does.
- Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the *'harmful use of alcohol'*, which incorrectly implies that there are *'safe levels'* of alcohol use and *'economic operators'*, which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.

There is much to be done if we are going to turn the tide on harmful alcohol consumption. For children whose lives are blighted and compromised by alcohol before they even take their first breath, this light-handed approach cannot continue.

Thank you for your consideration.

Yours sincerely,



Maria Catterick
Director
FASD Network UK

FASD Okanagan Valley Assessment and Support Society

Country/Location: Canada

URL: <https://www.fasdokanagan.ca>

Submission

Suggestion:

Fetal Alcohol Spectrum Disorder (FASD) is an important harm from use of alcohol but is not -as of Nov 26, 2020- yet included in the Global Strategy to Reduce the Harmful Use of Alcohol working document.

FASD profoundly affects life expectancy. (Statistic A in attached submission)

Care for individuals affected by FASD is costly for society. (Statistic B in attached submission)

FASD is NOT a "niche" issue...it is a very common condition. (Statistic C in attached submission)

Alcohol use in pregnancy is a global issue. (Statistic D in attached submission)

Alcohol use in pregnancy can be up to 80% in some advanced countries. (Statistic E in attached submission)

A study from the USA showed half of the mother drank alcohol before they knew they were pregnant; after recognition of the pregnancy 13% continued to drink alcohol (although 6.6% reduced their intake.)

(Statistic F in attached submission)

The five countries with the highest prevalence of prenatal alcohol use belong to WHOEUR; 36-60% of pregnant women drink alcohol in these countries. (Statistic G in attached submission)

Attachment(s): 1

00091_06_statistics-relevant-to-who-global-strategy-to-reduce-the-harmful-use-of-alcohol.pdf

Statistic	Reference
<p>A) The life expectancy at birth of people with FAS was 34 years (95% confidence interval: 31 to 37 years), which was about 42 % of that of the general population.</p>	<p>Thanh NX, Jonsson E. 2016. <i>Life Expectancy of People with Fetal Alcohol Syndrome</i>. Journal of Population Therapeutics and Clinical Pharmacology 2016; Vol.23 (1): e53-e59</p>
<p>B) The total annual cost of FASD in Canada has been estimated at \$9.7 billion a year (in 2014 Canadian dollars), of which the criminal justice system (that is, crime) accounts for 40%, health care for 21%, education for 17%, social services for 13%, and others for the remaining 9%</p>	<p>Thanh NX, Jonsson E, <i>Costs of Fetal Alcohol Spectrum Disorder in the Canadian Criminal Justice System</i>. J Popul Ther Clin Pharmacol 2015;22(1): e125-31</p>
<p>C) FASD impacts approximately <u>4%</u> of Canadians.</p>	<p><i>Canada FASD Research Network Facts page</i>, accessed Nov 26, 2020 at: https://canfasd.ca/fasd-facts/</p>
<p>D) Alcohol use in pregnancy remains common with the global prevalence of alcohol use in pregnancy from 1984 to 2014 estimated to be 9.8%</p>	<p>Popova S, Lange S, Probst C, Gmel G, Rehm J <i>Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis</i>. Lancet Glob Health. 2017 Mar; 5(3):e290-e299.</p>
<p>E) According to an international multicenter cross-cohort comparison, the rates of alcohol use in pregnancy ranged from 20% to 80% in Ireland and 40% to 80% in Australia, New Zealand, and the United Kingdom</p>	<p>O'Keeffe LM, Kearney PM, McCarthy FP, Khashan AS, Greene RA, North RA, Poston L, McCowan LM, Baker PN, Dekker GA, Walker JJ, Taylor R, Kenny LC. <i>Prevalence and predictors of alcohol use during pregnancy: findings from international multicentre cohort studies</i>.BMJ Open. 2015 Jul 6; 5(7):e006323.</p>
<p>F) The 2002-2009 Pregnancy Risk Assessment Monitoring System data set showed that in that sample, 49.4% of women reported drinking alcohol before pregnancy and that among these women, ~87% quit during pregnancy, 6.6% of women reduced their intake, and 6.4% did not change</p>	<p>Kitsantas P, Gaffney KF, Wu H, Kastello JC. <i>Determinants of alcohol cessation, reduction and no reduction during pregnancy</i>. Arch Gynecol Obstet. 2014 Apr; 289(4):771-9.</p>

their intake.	
G) The five countries with the highest estimated prevalence of alcohol use during pregnancy were Russia (36·5%, 95% CI 18·7–56·4), UK (41·3%, 32·9–49·%), Denmark (45·8%, 30·9–61·2), Belarus (46·6%, 42·4–50·7; based on prediction), and Ireland (60·4%, 42·8–76·8); all of which belong to WHO EUR.	Popova S, Lange S, Probst C, Gmel G, Rehm J <i>Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis.</i> Lancet Glob Health. 2017 Mar; 5(3):e290-e299.

FEDERACION ESPAÑOLA DEL VINO - FEV

Country/Location: Spain

URL: www.fev.es

Submission

Considering the above mentioned (in the attached document) and from our national perspective, we would like to share the following comments regarding the global strategy to reduce the harmful use of alcohol:

- The Global Strategy to reduce the harmful use of alcohol contributed to the significant reduction of harmful drinking that has been registered in the last decade as several reports showed.
- The action plan should recognise the positive contribution of economic operators in reducing the harmful use of alcohol, as mentioned before.
- All elements of the action plan should be consistent with the Global Strategy to reduce the harmful use of alcohol and the 2018 UN Political Declaration.
- The identification of high impact policy options should be done at national or regional level to better adapt efficient solutions to the national or regional specificities including socio-economic and cultural.
- Focus should be maintained on the harmful use of alcohol and not on consumption per se
- We consider very important to promote effective long-term measures as:
 - Information campaigns with multi-stakeholders approaches and public-private initiatives on healthy lifestyle option such as healthy Mediterranean-style diet, which can include low to moderate wine consumption and responsible drinking patterns are among the most efficient tools
 - Education campaigns that focus on modifiable lifestyle factors that accounts the most to the overall diseases incidence
 - Avoiding the imposition of measures relatives to price regulation, including taxation, which have proven to have very limited effect on excessive drinkers who are the most exposed to the risks of harmful drinking. Also, they have undesirable side effects in creating extra incentives for illicit alcohol manufacture and sale
- Promoting a healthy lifestyle should be a key point in the strategy. The importance of training, information, education actions and awareness campaigns aiming at promoting moderation and responsibility towards drinking among consumers and professionals should be enhanced in the draft action plan for a more effective implementation of the GAS. The following topics should be addressed in the above-mentioned actions: the drinking patterns (drink within meals, alternate with water, drink in moderation); the drinking guidelines; who should not drink, the risk linked to excessive alcohol consumption, etc.

- A global strategy shouldn't ignore the many different cultural and social approaches to alcohol consumption around the world
- Policy decisions should be science and fact based
- Private sector should not be treated differently in its relations with WHO in comparison with other non-State actors as public-private partnership is key to develop effective measures in a long term basis.
- The draft action plan should remain consistent with the Global Strategy which does not identify the development of international labelling standards of alcoholic beverages as an area of action of the Global Strategy. Also should acknowledge the works of an international standard for wine labelling already develop by an intergovernmental organisation – the International Organisation of Vine and Wine (OIV). OIV, which is a reference for the for the regulation of its 47 members and specially for the EU, has among its objectives the protection of health of the consumers and aim to contribute to food safety.
- Finally, we fully agree with all specific comments delivered by our european association, Comité Européen des Entreprises Vins (CEEV)

Attachment(s): 1

00385_41_fev-comments-gas.pdf

FEV contribution

to the WHO Web based consultation on a working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol

ABOUT FEV

The Spanish Wine Federation (FEV-Federación Española del Vino) is the national association that represents the Spanish wine sector among the Spanish, European and international authorities. FEV has more than 700 members and is an active participant in Comitée Européen des Entreprises Vins (CEEV), the European representative of 23 national organizations.

We are also promoters and members since 2008 of Wine in Moderation, an international social responsible leading program that works with wine companies and other stakeholders of the value chain to responsibly present, sell and serve wine, inspiring them to talk about the benefits of the moderate consumption of wine and be aware of the risks of alcohol abuse with tangible and relevant actions which will help their customers take informed decisions, share and enjoy wine in a caring and sustainable way.

ABOUT SPANISH WINE SECTOR

The Spanish wine sector, ranging from small family owned wineries to multinational companies, is strongly committed to continue its action through the Wine in Moderation movement to promote responsible wine consumption and contribute to reduce the harm related to excessive/irresponsible drinking. The mission to self-regulate commercial communication, to educate, inform and communicate on the topic of moderate and responsible wine drinking as part of a healthy diet and lifestyle is achieved through a variety of actions at local and international level targeting wine professionals and consumers.

Thanks to, among others, information campaigns with multi-stakeholders approaches and public-private initiatives like www.wineinmoderation.com, consumers:

- are better informed about the healthy lifestyle options that can contribute to reduce the risks related to the harmful use of alcohol
- have adopted at least some modifiable lifestyle factors such as eating a balanced and healthy diet (Mediterranean style diet), drink moderately wine with the meals, and have a better knowledge of responsible consumption patterns

As part of that task, the Spanish wine sector is leader on promoting self regulation on commercial communications that has been successful over the years. In the wine sector, the communication and advertising strategy has always tried to encourage and induce moderation as the only possible form of consumption. For that reason, wine has always been linked to gastronomy or to a leisurely enjoyment, with the purpose of appreciating all the nuances every glass of wine has to offer.



Nevertheless, aware of the harms that alcohol abuse can bring to society, in 2008 and within the framework of the Wine in Moderation program, the Federación Española del Vino (FEV) –Spanish Wine Federation– approved the Wine Self-Regulation Code in the Matter of Advertising and Commercial Communications, which reinforced the traditional wine communication with a number of rules to be met by wine companies when elaborating their messages.

In 2018, the Organización Interprofesional del Vino de España (OIVE), on behalf of the wine sector, reinforced and expanded this previous commitment with society through this Code of Commercial Communications of Wine that constitutes a further step towards the responsibility of the Spanish winemaking sector as a whole. The present Code, besides assuring the messages of moderation in wine communication, also entails a work of clarification for some implementation aspects that raised doubts, and an increase in the degree of protection for groups or situations in which the wine is incompatible, such as minors, consumption during pregnancy and driving.

Also, together with the [Interprofesional del Vino de España](#) and the Foundation for Research of Wine and Nutrition ([FIVIN](#)) we work on implementing measures and activities to inform and educate consumers about the risks of harmful consumption and to promote healthy lifestyles where there is a space for moderate/light consumption of wine as many scientific evidence says.

We believe the success of all those actions will be reflected in a long term lower disease incidence and mortality among citizens.

By the way, levels of alcohol consumption in Spain have been decreasing progressively over the past 30 years. Spain has a national policy of minimum age for selling alcohol and all of the 17 regions have policies in place to ban the sale and serving of any type of alcohol under age. Spain has also adopted policies of sales restriction of alcoholic beverages (e.g. in petrol stations or at specific events) as well as regulations of advertisement of alcohol products.

ABOUT GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL

Considering the above mentioned and from our national perspective, we would like to share the following comments regarding the global strategy to reduce the harmful use of alcohol:

- The Global Strategy to reduce the harmful use of alcohol contributed to the **significant reduction of harmful drinking that has been registered** in the last decade as several reports showed.
- The action plan should recognise the **positive contribution of economic operators** in reducing the harmful use of alcohol, as mentioned before.
- All elements of the action plan should be **consistent with the Global Strategy to reduce the harmful use of alcohol and the 2018 UN Political Declaration**.

- The identification of high impact policy options should be done at **national or regional level to better adapt efficient solutions** to the national or regional specificities including socio-economic and cultural.
- Focus should be maintained on the **harmful use of alcohol** and not on consumption per se
- **We consider very important to promote effective long-term measures as:**
 - Information campaigns with multi-stakeholders approaches and public-private initiatives on healthy lifestyle option such as healthy Mediterranean-style diet, which can include low to moderate wine consumption and responsible drinking patterns are among the most efficient tools
 - Education campaigns that focus on modifiable lifestyle factors that accounts the most to the overall diseases incidence
 - Avoiding the imposition of measures relatives to price regulation, including taxation, which have proven to have very limited effect on excessive drinkers who are the most exposed to the risks of harmful drinking. Also, they have undesirable side effects in creating extra incentives for illicit alcohol manufacture and sale
- **Promoting a healthy lifestyle should be a key point in the strategy.** The importance of training, information, education actions and awareness campaigns aiming at promoting moderation and responsibility towards drinking among consumers and professionals should be enhanced in the draft action plan for a more effective implementation of the GAS. The following topics should be addressed in the above-mentioned actions: the drinking patterns (drink within meals, alternate with water, drink in moderation); the drinking guidelines; who should not drink, the risk linked to excessive alcohol consumption, etc.
- A global strategy **shouldn't ignore the many different cultural and social approaches to alcohol consumption** around the world
- Policy decisions should be **science and fact based**
- **Private sector should not be treated differently** in its relations with WHO in comparison with other non-State actors as public-private partnership is key to develop effective measures in a long term basis.
- The draft action plan should remain consistent with the Global Strategy which does not identify the development of international **labelling standards of alcoholic beverages** as an area of action of the Global Strategy. Also should acknowledge the works of an international standard for wine labelling already develop by an intergovernmental organisation – the [International Organisation of Vine and Wine](#) (OIV). OIV, which is a reference for the for the regulation of its 47 members and specially for the EU, has among its objectives the protection of health of the consumers and aim to contribute to food safety.
- Finally, we fully agree with all specific comments delivered by our european association, [Comité Européen des Enterprises Vins](#) (CEEV)

Federvini

Department/Unit: -

Country/Location: Italy

URL: www.federvini.it

Submission

we ask to better consider cultural targets and cooperation inside the plan; and to avoid generic indicators as an instrument for focusing local performances.

Attachment(s): 1

00321_04_culture-cooperation.pdf

FEDERVINI

Federazione Italiana Industriali Produttori, Esportatori ed Importatori
di Vini, Acquaviti, Liquori, Sciroppi, Aceti ed affini



Via Mentana, 2b - 00185 Roma
Telefono: (06) 4941630 - 4469421
Telefax: (06) 4941566
Sito web: www.federvini.it
e-mail: federvini@federvini.it

Culture and Cooperation

Federvini is the Italian wine, spirit and vinegar industries national federation.

Because of companies' interests, Federvini pays special attentions on responsible production, presentation and marketing of wines, spirits.

Federvini is proud to be part of an historical region – the Mediterranean region – which has been repeatedly studied for its positive food & drinks consumption habits.

In this frame, we would like to highlight a first concern: to use per capita alcohol consumption target does not appear as a useful target and/or indicator to establish an efficient strategy to reduce harmful use of alcohol.

Looking to the Mediterranean region and our Italian experience, general and “anonymous” capita alcohol consumption shows an important decrease, well over WHO targets. To continue on this thought we ask WHO to better highlight and consider cultural and social differences when tailoring specific policies. Global & worldwide targets and policies seem not to be the better approach, particularly to reach consumers exposed to risk of harmful consumptions.

We respect and share WHO concerns on alcohol harmful use and we are ready to act as responsible stakeholder to cooperate in reducing harmful consumptions. To do it, we ask WHO to not exclude wine and spirits producers from policy dialogue, but to involve them in standard options and definitions which in many important Regions – and the Mediterranean is one of them – gave important and positive results.

Finally, and once again, we ask WHO to include and support cultural leverages, particularly when strategies are defined and addressed to intervene on health policies and meet specific social targets.

We thank WHO for the attention will be paid to the raised points.

Finnish institute for health and welfare

Department/Unit: *Department of public health solutions*

Country/Location: Finland

Submission

In our statement to the WHO we focus on three topics:

Importance of high-impact policy and interventions

Protection from commercial interests

Resource mobilization

Attachment(s): 1

00223_34_statement-to-the-who.pdf

Thomas Karlsson, Pia Mäkelä, Katariina Warpenius

December 7, 2020

World Health Organization (WHO)
Alcohol, Drugs and Addictive Behaviours Unit

Statement from researchers in the Finnish Institute for Health and Welfare (THL) to WHO consultation on the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

We in the Finnish Institute for Health and Welfare (THL) applaud the effort of the WHO to boost the implementation of the Global Strategy by the Action Plan and wish to comment as follows:

Importance of high-impact policy and interventions

The proposed six key areas for global action are all highly relevant, although the first action area **“implementation of high-impact strategies and interventions” is the most important one**. THL supports the conclusion that the goal of reducing morbidity and mortality due to alcohol use can be achieved by increasing population coverage and strengthening implementation of measures with proven effectiveness, and that these measures can be implemented in countries with different levels of available resources. In this the policy options and interventions included in the **SAFER initiative are of highest importance and should in our view be considered as the backbone of the action plan**. These methods will be efficient in reducing not only NCDs but also injuries, violence, infectious diseases and a “harm to others”.

Protection from commercial interests

In order to boost the implementation of effective alcohol policies, a key prerequisite is to defend **the principle of protection from commercial interests, i.e from interests of alcohol industry entities, as these interests are in an inherent conflict with the goal of reducing morbidity and mortality due to alcohol use**. Therefore, we highly support the statements presented in the document that economic operators in the alcohol field should refrain from activities that may prevent or delay the development or enactment of high-impact strategies and interventions and they should refrain from interfering with alcohol policy development and evaluation, engagement in capacity-building activities and also from direct funding of public health and policy-related research.

Thomas Karlsson, Pia Mäkelä, Katariina Warpenius

December 7, 2020

Resource mobilization

A significant obstacle for implementation of the Global Strategy to reduce the harmful use of alcohol both globally and nationally is a lack of resources for the work. With this in mind, the cost-effectiveness of alcohol control measures should be underlined when raising awareness among policy-makers and the general public. But in particular, **“resource mobilization” in all areas from development, implementation, monitoring and research of alcohol policy and treatment should have a high priority** when implementing the action plan in the future.

Thomas Karlsson,
Team leader, Chief specialist

Pia Mäkelä,
Research professor

Katariina Warpenius
Senior researcher

Finnish Institute for Health and Welfare (THL)
WHO Collaborating Centre on Alcohol Policy Implementation and Evaluation

The Finnish Institute for Health and Welfare (THL) is a research and development institute under the Finnish Ministry of Social Affairs and Health. It studies, monitors, and develops measures to promote the well-being and health of the population in Finland. It gathers and produces information based on research and register data, and provides expertise and solutions to support decision-making.

FIVS

Department/Unit: *FIVS Secretariat*

Country/Location: United States of America

URL: www.fivs.org

Submission

Yes, please see attached response.

Attachment(s): 1

00355_25_fivs-response-to-who-working-document-2020-12-11.pdf



**FIVS's Written Response
to the WHO's Working Document
11 December 2020**

Established nearly seventy years ago, [FIVS](#) is a non-governmental organisation that for many years has been committed to encouraging its members and the wider industry to conduct their business in a manner consistent with the principles of sustainable development. In pursuing this activity, FIVS gathers and disseminates information primarily related to the wine sector, but also to a lesser extent, related to the beer and spirits sectors, of interest to its members. Based in Paris, FIVS's membership is global, including members from 27 countries, as well as the European Union, and comprises producers, distributors, importers, exporters, and trade associations. FIVS members presently account for around 75 percent of wine traded globally. Through our trade association members, FIVS represents the voices of over 10,000 wine producers, reflecting both the breadth of our coverage and the degree to which the wine industry is highly fragmented. FIVS operates by consensus so those positions that it advocates to international and intergovernmental organisations, as well as to governments, have been agreed upon by its full membership, amounting to the commitment of the majority of wine producers globally.

Our experience has shown that the wine, beer, and spirits sectors have worked well with governments, international bodies, and other stakeholders around the world to deliver successful outcomes regarding public policy matters, including reducing the harmful use of alcohol. Indeed, FIVS itself has formed many successful partnerships on behalf of its members with international and intergovernmental organisations. A recent FIVS publication, [FIVS & the United Nations Sustainable Development Goals: Walking the Talk](#), demonstrates how our organisation encourages our membership to conduct business responsibly and to engage more

actively in the area of sustainable development. FIVS initiatives over the past 15+ years have included:

- [FIVS-Assure](#), a publicly available online database, created and maintained by FIVS, that gathers resources on social aspects programmes in the wine, spirits, and beer sectors. This tool draws upon exemplary practices by FIVS members, companies, trade associations, and other entities from around the world. This month, FIVS will be launching a new version with over 100 entries, including information about national drinking guidelines from around the world, featured initiatives, and an enhanced user interface.
- [FIVS's Guiding Principles for Advertising and Marketing](#), which outlines the major principles for the advertising and marketing of alcohol beverages, including the representation of moderate and responsible consumption, no depiction of minors, and abstaining from linking consumption with therapeutic benefits or personal success. FIVS updated those principles with an Annex on Digital Marketing to ensure that digital campaigns are not accessible to underage users and that user privacy is protected in digital marketing.
- [FIVS Social Sustainability Principles for Ethical Trading](#), which were adopted by FIVS to promote conducting business with respect for human rights and ensuring lawful, fair, and ethical behaviour in all commercial dealings.
- A [new publicly available page dedicated to COVID-19](#) on the FIVS website, which offers practical resources, technical and sanitary measures, guidelines, and trends in response to the coronavirus pandemic.
- A memorandum of understanding with Wine in Moderation, emphasizing responsible drinking and moderate wine consumption globally and increasing awareness of the significance of drinking in moderation. The two organisations have worked collaboratively to promote responsible consumption.

The alcohol beverage sector has made significant progress in reducing harmful drinking. As the WHO's status report from 2018 indicates, alcohol-related death rates have fallen globally by 13 percent from 2010 to 2016, heavy episodic drinking has decreased by 11 percent, and heavy episodic drinking by 15 to 19 years old individuals has dropped by 13 percent. Examples of government working in partnership with industry include the Responsibility Deal, stimulating increased availability of non- and lower-alcohol beverages in the United Kingdom; Drinkaware, providing facts and tools to help people in the United Kingdom make healthy choices regarding their consumption; and the 2018 Alcohol Framework to prevent underage drinking and promote smaller wine purchases in pubs in Scotland.

We have read the working document for the development of an action plan to strengthen implementation of the Global Strategy to reduce the harmful use of alcohol. As requested, we would like to offer the following comments and suggestions, which reflect our major concerns, for your consideration:

1. As currently drafted, the working document questions the commitment of economic operators to public health, contradicting the United Nations Political Declaration's statement that economic operators have a role to play in producing positive health outcomes. **We encourage the WHO Secretariat to recognise the positive contributions of economic operators in reducing the harmful use of alcohol and to include economic operators within a whole-of-society approach at all levels – multilateral, regional, and national.** Using our unique expertise, insights, and resources, in addition to our support for co-regulatory systems, economic operators have produced tangible results in addressing harmful drinking and underage drinking, which are both decreasing. As noted above, the prevalence of heavy episodic drinking has decreased globally from 2010 to 2016, although it has remained high in parts of Eastern Europe and sub-Saharan Africa, and consumption among young people has fallen in many European countries and in some high-income countries.
2. We wish to stress that **the action plan's recommendations should focus on reducing the harmful use of alcohol as a public health priority, rather than reducing total**

alcohol consumption on a per capita basis. The working document as currently drafted is not consistent with the Global Strategy, the 2018 United Nations Political Declaration on non-communicable diseases, or the directions given to the World Health Organisation by Member States during previous Executive Board meetings and World Health Assemblies. Total alcohol per capita consumption alone is not an adequate indicator of the harmful use of alcohol, as it does not differentiate among light, moderate, and heavy drinking. Indeed, sales do not necessarily equal consumption, particularly in the case of wine, which has a long shelf life and is often purchased with an intent to be stored for years.

3. Although illicit trade does not involve wine as often as other sectors, **we encourage the WHO Secretariat to give more attention to the illicit market.** As the working document notes, illicit alcohol accounts for 25 percent of alcohol consumption per capita globally and more than half of all alcohol consumed in some jurisdictions. Economic operators can support efforts to identify data and trends to track the illicit market.
4. We note further that **the working draft proposal regarding development of international standards for labelling alcohol beverages by the WHO Secretariat is inconsistent with the Global Strategy,** which instead preserves labelling as a policy option for Member States. Additionally, ongoing multilateral Codex Alimentarius deliberations on the labelling of alcohol beverages should not be pre-empted or disrupted by this proposal.
5. Similarly, **the working document should not suggest an expanded role for the WHO Secretariat related to international trade.** International trade is within Member State competence, and at the multilateral level, international trade is within the purview of the World Trade Organisation. As such, the action plan should not advance proposals in the case of international trade.

We thank the WHO Secretariat for developing the draft document for the action plan, as well as for the opportunity to respond. FIVS looks forward to continuing to work cooperatively with all key stakeholders in promoting the responsible consumption of wines, spirits, and beers, while reducing harmful alcohol consumption.

Please let us know if you have any comments or questions by contacting Bennett Caplan, FIVS's Head of Secretariat at bcaplan@fivs.org or +1 202 486-1390.

Foro Regulación Inteligente

Department/Unit: *CEO*

Country/Location: Spain

URL: <http://regulacioninteligente.org/>

Submission

In the attached document, we submit our comments regarding the working document.

Some of our key points:

- The overall trend is favorable and new regulatory approaches must be prudent.
- WHO must stress the fight against illegal alcohol.
- The focus must be on preventing excessive/harmful consumption, not overall drinking.
- One size does not fit all: regional and national strategies are better suited.

Attachment(s): 1

00107_08_who-consultation-on-alcohol-regulation-foro-regulacion-inteligente.pdf

November 30, 2020
MADRID, SPAIN
FORO REGULACIÓN INTELIGENTE

WHO consultation on alcohol regulation

Our organization, *Foro Regulación Inteligente*, is an independent think tank based in Madrid, Spain, that aims to improve the regulatory environment in which companies and citizens operate. We welcome the opportunity to contribute our ideas and proposals through this public consultation.

We acknowledge the improvements made by the WHO's new working document on alcohol regulation in matters such as the limitation of access by minors or the design of special strategies related to consumption under exceptional circumstances, such as lockdowns enacted due to the covid-19 pandemic.

However, moving forward, we think the WHO should consider the following points:

- *The trend is favorable.* According to the WHO itself, the evolution of alcohol consumption describes a downward slope since 2010. Only one in two people say they have consumed alcohol during the last year and the percentage of people who consume alcohol on a regular basis is even lower (around 30%). In addition, the percentage of people who consume more than 60 grams of alcohol per month has fallen since 2010 and 2016, going from 20.6% to 18.5%.¹ Faced with this positive trend, WHO and national authorities should exercise caution and regulatory prudence.
- *More regulation does not equal better regulation.* Publications such as the *Nanny State Index* certify that a higher level of regulatory restrictions does not always lead to lower consumption.² With a similar level of limitations, per capita consumption in Belgium doubles that of Greece and Italy. Similarly, although Lithuania and Sweden maintain similar constraints, the Baltic country almost triples the per capita consumption levels seen in Sweden.
- *No significant progress has been made against the scourge of illegal alcohol trade.* The irregular sale of this type of beverages accounts for 25% of the global consumption, creating a serious void in any public health strategy and raising significant challenges for public health as a result of the massive circulation of products that lack proper sanitary controls.³ It is worrying that this type of irregularity continues to have such a high scope and the WHO should make this issue one of the key points of its future strategy.
- *Tax increases are not the solution.* The WHO has found that levels of alcohol consumption are higher in countries with greater levels of per capita income. In this sense, *The Lancet* magazine has published studies that certify a much higher consumption

among sociodemographic groups with higher incomes (72% women, 83% men, as opposed to 8.9% women, 20% men among groups with lower incomes.⁴ Therefore, proposing measures aimed at increasing the price of alcohol through tax increases seems a strategy doomed to failure, since we are talking about consumer goods with relatively inelastic demand patterns whose intensity increases as incomes are higher. In addition, it is a regressive measure that also has the incentive to drive lower-income people towards the “black market”, with all the negative implications this has for public health (and tax revenues).

- *One size does not fit all.* *The Lancet* magazine has certified that the evolution of alcohol consumption presents different patterns depending on the country we analyze. Thus, since 2010, we find increases in Japan (+ 11.3%) or the United States (+ 5.4%), while percentages for France, Germany or Spain remain stable, and figures for the United Kingdom (-7.3%), Canada (-10.8%) or Australia (-14.4%) point to a downward trend.⁵ Considering these great differences, it seems logical to explore the possibility of establishing recommendations or strategies in a more decentralized way, considering the reality of each country, as recommended by the second principle of the 2010 Global Strategy.

- *Prevention must focus on risk groups and excessive consumption.* Statistics show that the vast majority of consumers consume alcohol responsibly. Therefore, public policy interventions should focus on protecting groups at risk and tackling the problems derived from excessive consumption. Thus, instead of proposing restrictions all across the board (i.e. advertising bans, higher taxes, limited hours for consumption...), the most sensible thing to do is to develop more precise interventions that tackle the troublesome aspects of consumption..

- *Do not ignore the ongoing economic crisis.* The covid-19 pandemic has had a devastating impact on the economy. The World Bank estimates that the recession of 2020 and the weak recovery of 2021 will increase the number of people living below the poverty line by 150 million.⁶ In this sense, it should be remembered that two of the industries hardest hit by this widespread impoverishment are the hotel and leisure industry, which have seen their activity significantly reduced due to the sanitary restrictions adopted by the authorities. A direct consequence of this situation is the rise in unemployment associated with people with less qualifications. Therefore, it is important to reflect on the severe economic cost that an excessively aggressive strategy could have, as it could result in lower activity and employment, with the corresponding impact on public health.

- *Push for R&D.* In recent years, the alcohol industry has followed the evolution of demand and has introduced healthier products, reducing calories, sugar or gluten content and developing promising developments such as synthetic alcohol. Companies should be

encouraged to deepen such good practices with public-private partnerships that accelerate research or tax incentives that fuel the attractiveness of such investments.

We appreciate that you take our ideas, proposals and clarifications into consideration and we are at your entire disposal to help you design an effective, lasting and sustainable strategy.

¹ World Health Organization, "Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol" (2020). Disponible en: <<http://www.who.int/docs/default-source/alcohol/alcohol-action-plan/for-web-working-document-for-action-plan.pdf>>.

² Epicenter, *Nanny State Index* (2019). Disponible en: <<http://nannystateindex.org>>.

³ Euromonitor, "Size and Shape of the Global Illicit Alcohol Market" (2018). Ver: <<http://go.euromonitor.com/rs/805-KOK-719/images/wplIllicitAlcoholMarket.pdf>>.

⁴ GBD 2016 Alcohol Collaborators, "Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016", *The Lancet* (2018). Disponible en: <[http://doi.org/10.1016/S0140-6736\(18\)31310-2](http://doi.org/10.1016/S0140-6736(18)31310-2)>.

⁵ Jakob Manthey, Kevin D Shield,, Margaret Rylett, Omer S. M. Hasan, Charlotte Probst y Jürgen Rehm, "Global alcohol exposure between 1990 and 2017 and forecasts until 2030: a modelling study" (2019). Disponible en: <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)32744-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32744-2/fulltext)>.

⁶ World Bank, "COVID-19 to Add as Many as 150 Million Extreme Poor by 2021" (2020). Disponible en: <<http://www.worldbank.org/en/news/press-release/2020/10/07/covid-19-to-add-as-many-as-150-million-extreme-poor-by-2021>>.

FORUT and partner organisations

Country/Location: Norway

URL: <https://forut.no/>

Submission

Key points:

- The working document describes in a comprehensive way the undisputable challenges that alcohol use causes for health and wellbeing worldwide.
- We suggest including a section on transnational alcohol corporations and their strategies, including their targeting of low- and middle-income countries, to achieve sales growth and to interfere in national public health policies.
- It is essential that the action plan is framed and broadly understood as an action plan to reduce harm from alcohol and promote public health
- We are deeply concerned that the economic operators are treated as an equal partner alongside other international partners and non-State actors with tasks under each of the action areas. The inclusion of the economic operators seems to ignore their commercial responsibilities to shareholders and the reliance on substantial sales on heavy drinking occasions and to individuals with alcohol use disorder. We suggest that the economic operators are taken out of each action area, and that their activities are shed light on in a separate paragraph or chapter where conflict of interest matters are analysed and clarified properly.
- We suggest, in relation to the economic operators, to adopt measures to increase transparency of commercial influence in policy making.
- We suggest that the Director General be requested to report to the WHA biennially on the progress of implementing the action plan.
- We suggest that a global instrument that is legally binding for all Member States must be considered if a review of the action plan implementation proves it to be an ineffective tool to reach the defined targets.
- We suggest that the document refers to the fact that in many cultures and populations non-drinking is the norm.
- We believe that the working document would benefit from a stronger equity lens that is embedded and made explicit throughout. There are ample examples of lack of adequate policy in LMICs, and there is a need for a strong mandate for LMICs to implement effective alcohol policies framed as public health instruments, not trade policies.
- From our experience as community-based organisations and civil society organisations from developing countries we see that we cannot raise living conditions and alleviate the negative impact on women and children without eradicating alcohol harm from the community.

- We suggest that the action plan be more strongly framed around every country implementing the 5 most effective, science-based interventions, as articulated in the SAFER guidance.

- We underline the need for the action plan to clearly reflect the concern about alcohol marketing increasingly being shifted to the digital arena. Also, considering the rapid expansion of social media and internet in the LMICs and the targeting of the young people in these countries by alcohol industry, high priority should be given to regulation of digital and cross-border marketing of alcohol products.

Attachment(s): 1

00332_11_submission-on-working-document-forut-and-partners-final-13.12.20.pdf

WHO ‘Working document for development of an action plan to strengthen implementation of the Global strategy to Reduce the Harmful Use of Alcohol’

Responses from FORUT – Campaign for development and solidarity, Norway, and partner organisations

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1. Introduction

FORUT is a Norway-based development NGO with a focus on alcohol and drug problems as a development issue. We work with partners from Asia and Africa. Several of them have contributed to and are signatories of this submission. They are:

Child Workers in Nepal Concerned Centre (CWIN-Nepal), Nepal
Rural Development Tuki Association (RDTA), Nepal
Foundation for Rural and Urban Transformation (FoRUT), Sierra Leone
Recovery and Humanitarian Action Management Agency (RAHAMA), Sri Lanka
West African Alcohol Policy Alliance (WAAPA)
Alcohol Policy Alliance Gambia (APAG)
Ghana Alcohol Policy Alliance (GhanAPA)
Association of Advocates Against Alcohol Harm in Nigeria (ASAAHN)
Liberia Alcohol Policy Alliance (LAPA)
Sierra Leone Alcohol Policy Alliance (SLAPA)
Benin Alcohol Policy Alliance (BAPA)
Senegalese Alcohol Policy Alliance (SenAPA)
Burkina Faso Alcohol Policy Alliance (APABurkina)
Guinea Bissau Alcohol Policy Alliance (GUIAPA)
Association for Promoting Social Action (APSA), India
Foundation for Innovative Social Development (FISD), Sri Lanka
Healthy Lanka, Sri Lanka
Forum for Rural Income and Environmental Development Services (FRIENDS), Sri Lanka

In the rest of the document “we” refers to FORUT and the signing partners.

We are thankful for the opportunity to give comments and feedback on the working document, and through that contribute to the important task of reducing harms from alcohol worldwide. We appreciate the effort by WHO in conducting such an ambitious consultative process. In general, we welcome and support large parts of the working document as elements of the future action plan. But we also see room for improvement and opportunities to strengthen the action plan.

Before we get to our comments and submissions, we want to stress that putting together this submission as civil society representatives has been a challenging task given the short consultation period of four weeks (originally three weeks). We fear that a consequence of the short deadline is that WHO misses the opportunity to have civil society and other relevant actors contribute to the action plan. We are aware that there will be opportunities to contribute later, but this is indeed a crucial time in the making of the action plan.

2. Problem description

We support WHO in recognising the need for more effective action and implementation of the Global strategy to reduce harmful use of alcohol (from 2010). The working document describes in a comprehensive way the undisputable challenges that alcohol use causes for health and wellbeing worldwide. Harm from alcohol affects many non-drinkers as well as drinkers themselves, including many children, as the working document describes in a good way.

The working document is evidently the result of in depth and lengthy preparations by the WHO secretariat, and we support the span of the document. The “Setting the scene” section encompasses the wider relevant context that the action plan, and the whole global alcohol policy field, must be

seen in relation to. This is especially the policies and actions on Non-Communicable Diseases (NCDs) and the Social Development Goals (SDGs). Nonetheless we have a few proposals for this section.

We suggest including a section on transnational alcohol corporations and their strategies, including their targeting of low- and middle-income countries, to achieve sales growth and to interfere in national public health policies.

We suggest that all the challenges listed should be more systematically addressed, since arguably not all the challenges listed are of the same significance and severity. For instance, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources. It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and must overcome.

We suggest conducting assessments on global and national levels of alcohol use and related problems and implementation of alcohol policies at least once in 2 years and make the data and information available to public.

3. Structure and length of the document

Although comprehensive, or perhaps because of this, the document is too long and confusing and might be too unmanageable to implement and to monitor.

We suggest that to strengthen the likelihood of the plan's success, actions must be prioritized based on evidence of effectiveness to encourage efficiency in resource utilization.

We suggest that the document is restructured in line with a logical approach that reflects the operational character of the action plan. This means going from overall *goals*, through *outcomes*, "down" to outputs and activities. This means streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization. Also we propose to identify responsible actors and stakeholder with targets, milestones and indicators for changes to be achieved.

4. The framing of the action plan

4.1 Public health, not profit

It is essential that the action plan is framed and broadly understood as an action plan to reduce harm from alcohol and promote public health. This means that trade or profit motives are irrelevant (both in objectives and action points). This is also in line with the request by the decision of the WHO Executive Board in February of 2020 to develop an action plan to implement the Global strategy as a *public health priority*.

Furthermore, we urge Member States to integrate alcohol policies as a public health issue into their national health priorities and policies.

4.2 Role of economic operators

We are deeply concerned that the economic operators are treated as an equal partner alongside other international partners and non-State actors with tasks under each of the action areas. The concern follows from the public health framing of the action plan (see above) and the operators' explicit conflict of interest and long record of opposing effective alcohol policies. The inclusion of the economic operators seems to ignore their commercial responsibilities to shareholders and the

reliance on substantial sales on heavy drinking occasions and to individuals with alcohol use disorder. We also know from many contexts worldwide, and especially in low- and middle-income countries, that in addition to making profit off a non-ordinary¹ and harmful commodity, the alcohol industry is trying to work its way into processes of alcohol policy making that should be off limits for them^{2,3}. Also, in the Covid-19 context we have seen how they are leveraging the pandemic for example by presenting themselves as part of the solution to both the pandemic and the consequences of lockdown⁴.

During the Covid-19 situation in Sri Lanka, the alcohol industry argued to keep alcohol available despite the lobbying by health workers and civil society organization to stop sales of alcohol. The industry argued that the government would be losing considerable revenue and that the availability of illicit alcohol and other drugs would increase. However, in reality people either reduced consumption or quit alcohol, tobacco and other drugs use during the Covid 19 lockdown periods⁵.

We therefore strongly oppose the invitation in the working document to the alcohol industry to contribute to reduce “the harmful use of alcohol in their roles as developers, producers and distributor/sellers of alcoholic beverages” (p. 15). We especially oppose the encouragement to “(...) contribute to the elimination of marketing and sales of alcoholic beverages to minors and targeted commercial activities towards other high-risk groups” (p. 12). More specifically, we do not oppose the industry refraining from these kinds of activities. We simply argue that an encouragement *not* to break the law of many countries is both superfluous and inappropriate in the action plan.

Taking into consideration the economic and political clout the economic operators have vis-à-vis the state actors and non-state actors, especially in the LMICs, treating these actors as equal actors in the fight against alcohol harm will have negative effects on public health policy formulation and implementation.

We argue that, given the weak evidence-base for the preferred approach by the industry to promote “responsible drinking”, it must be considered only as a façade to promote alcohol use and increase revenues while portraying the alcohol industry and their surrogates as benevolent actors.

Furthermore, evidence from the implementation of Framework Convention on Tobacco Control (FCTC) extols the benefit of keeping out the economic operators in the implementation of such global health instruments.

We suggest that the economic operators are taken out of each action area, and that their activities are shed light on in a separate paragraph or chapter where conflict of interest matters are analysed and clarified properly. The term non-state actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption, while civil society promotes the public interest in protecting people, communities, and societies from alcohol harm.

4.3 Transparency

We suggest, in relation to the economic operators, to adopt measures to increase transparency of commercial influence in policy making. The purpose is to register and counteract industry influence on the adoption and implementation of alcohol policies of the Member States. This would mean to develop a transparency register/database of special interest groups whose goal is to influence policy set up by WHO. The register would make visible what interests are being pursued, by whom and with what budgets. In this way, the register allows for transparency and public scrutiny.

5. Mandate: Whose action plan is it?

The working document proposes actions for many actors: “(...) Member States, the WHO Secretariat, international and national partners and, as appropriate, other stakeholders (p. 10). As far as we can see, the document does not define the status of each of the actors. From the wording we see that the actions proposed for the Member States and the WHO Secretariat have a more mandatory “style”. On the other side the international partners and non-State actors are only “invited” or “encouraged to” take action in different areas.

FORUT suggests that the action plan defines the status of the different actors, and that it also is clear on the fact that national governments are the most important actors. The essential question is: what does the action plan need to do to get governments to implement evidence-based policies? To be short, here is our proposal for a list of actors:

1. *Member States* are the most important actors because there needs to be government action to tackle this problem by implementing policies.
2. Alcohol harm is also an issue of transnational character, which gives *WHO* a crucial role in putting in place global instruments and monitoring structures to hold the Member States accountable and have them comply with the action plan. *WHO* also must play a crucial advisory and support role to the Member States.
3. *Civil society* can help and should be supported.
4. *Industry* is not a legitimate actor in the plan.

6. Timeframe, reporting and a “plan B”

6.1 Reporting

We are concerned about the lack of specific time intervals for review and reporting of the implementation of the action plan. This must be in place, otherwise the world community will have no tools to document the progress in the targets and indicators set for the action plan.

We suggest that the Director General be requested to report to the WHA biennially on the progress of implementing the action plan.

We suggest that there must be a point in the 8-year period for assessing whether a plan B needs to be considered. To be clear, if the reduction in the targets in the action plan are not in the process of being met by for example 2028, a plan B must be developed. Otherwise, we fear that we reach 2030 without targets met, without a Global strategy, and without an action plan. This must be avoided.

We suggest that Member States are urged to develop and implement monitoring and evaluations mechanism to collect, analyse and publish information and data alcohol use, related harm on the effective implementation of national policies and strategies to reduce alcohol problems.

6.2 The need of a legally binding instrument

There has been debate for some time about the need for a new global legally binding instrument to tackle alcohol harm worldwide. This kind of instrument (by some framed as a framework convention on alcohol control) was not adopted by the WHO Executive Board in February of 2020. The working document still mentions the argumentation for this kind of instrument very clearly: “Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. This absence limits the ability of national and subnational governments to regulate the distribution, sale, and marketing of alcohol within the context of international, regional and bilateral

trade negotiations, as well as to protect the development of alcohol policies from interference by transnational corporations and commercial interests” (p. 4).

We suggest that a global instrument that is *legally binding* for all Member States should be the plan B mentioned under 6.1., i.e., if a review of the action plan proves it to be an ineffective tool to reach the defined targets. The structure and mandate of such an instrument is of course too early to define, but at least three important aspects need to be discussed and included: Sufficient degree of *obligations* for the Member States, adequate *precision* in its requirements, and an appropriate degree of *delegation* between different levels in the implementation of instrument⁶.

7. There are more “norms”

The working document states that the “(...) drinking of alcoholic beverages is strongly embedded in the social norms and cultural traditions of many societies” (p. 4). As true as this may be, we claim that the document lacks a sensitivity to cultures where alcohol is *not* an embedded part of the culture. Alcohol use is not a universal socio-culturally embedded phenomenon in most of the cultures of the world especially in the LMICs

We suggest that the document refers to the fact that in many cultures and populations non-drinking is the norm. The action plan needs to reflect the Guiding principle no 7 of the Global strategy: “Children, teenagers and adults who choose not to drink alcoholic beverages have the right to be supported in their nondrinking behaviour and protected from pressures to drink”.

It should also be noted that cultural traditions of alcohol use are grounded in informal or small-scale production of alcohol, and that these are now replaced by large scale commercial production, distribution, and marketing of global alcohol brands. From this follows increased risks for harm.

8. Global health equity and focus on low- and middle-income countries

The working document states that “[t]he disproportionate prevalence of effective alcohol control measures in higher-income countries raises questions about global health equity; it underscores the need for more resources and greater priority to be allocated to support the development and implementation of effective policies and actions in low- and middle-income countries [LMICs]” (p. 2).

We applaud this focus, but we believe that the working document would benefit from a stronger equity lens that is embedded and made explicit throughout. All decisions and actions (by Member States and others) must consider and plan for equity from the outset. There are ample examples of lack of adequate policy in LMICs, and there is a need for a strong mandate for LMICs to implement effective alcohol policies framed as public health instruments, *not* trade policies. This need is reinforced by the fact that the health burden from alcohol is highest in lower-middle- and low-income countries, where the social and economic safety nets, as well as health institutions, are less developed⁷. These are also countries with few of the effective alcohol policies enumerated by the Global strategy in place. Adding to the burden is the fact that as high-income countries have become saturated and more health-oriented, alcohol producers have turned to the markets of countries with growing economies, youthful and urbanising populations, and where the prevalence of drinking commercial alcohol is lower than in high-income countries.

We have several years of experience as community-based organisations and civil society organisations from developing countries involved in rural and urban poor communities to raise the level of living conditions, specifically focusing on women and children. From this experience we see

that we cannot raise living conditions and alleviate the negative impact on women and children without eradicating alcohol harm from the community.

In addition to the “best buys” / SAFER measures (see below) which may be less effective in LMIC where resources are scarce, alcohol harm needs to be addressed at the local level. Community mobilisation and locally based prevention approaches and strategies have a role to play.

Considering the limited resource and infrastructural limitations of LMICs, effective prevention strategies to promote alcohol free lifestyles and social milieus through community actions and empowerments should be integral part of the action plan for reducing harm related to alcohol use.

9. Prioritise the three ‘Best Buys’ in SAFER

The documentation on what are effective interventions to reduce alcohol harm has grown in the past ten years and are today ample. The main issue now is to make sure that effective policies are understood and implemented worldwide. The numerous and sometimes overlapping recommendations in the draft document tend to obscure a focus on the most cost-effective policies to reduce alcohol-related harms.

WHO should advocate with member states to integrate and implement evidence-based strategies to reduce alcohol and related harms in the SDGs and other development policies and strategies.

We suggest that the action plan be more strongly framed around every country implementing the 5 most effective, science-based interventions, as articulated in the SAFER guidance: strengthening restrictions on alcohol availability; advancing and enforcing drink driving counter measures; facilitating access to screening, brief interventions, and treatment; enforcing bans or comprehensive restrictions on alcohol advertising sponsorship and promotion; raising prices on alcohol through excise taxes and pricing policies.

We suggest that the monitoring indicators should include specific metrics of SAFER implementation, and countries’ reporting on the implementation of SAFER policies should be supported. This is especially important in LMICs, which currently lack adequate resources and are often subject to interference from commercial interests.

10. Regulations of digital and cross-border marketing

Alcohol marketing is essential for the transnational alcohol corporations, both in its direct recruitment of drinkers and building of brand allegiance, and in normalising alcohol use in new contexts. Alcohol marketing resources are increasingly being shifted to the digital arena, in the same way as for many other products, particularly in the social media platforms. It is becoming more and more clear “that traditional ways of regulating the alcohol industry and products are proving impotent to achieve long-established public health goals in the era of social media and digitised services”⁸.

The WHO Executive Board recognises this emerging problem, and the February 2020 decision expressed “deep concern that alcohol marketing, advertising and promotional activity, including through cross-border marketing, targeting youth and adolescents, influences their drinking initiation and intensity of drinking”⁹. Therefore, the EB requested the Director General to develop a technical report addressing this problem.

We underline the need for the action plan to clearly reflect this concern and the findings of that report. Also, considering the rapid expansion of social media and internet in the LMICs and the

targeting of the young people in these countries by alcohol industry, high priority should be given to regulation of digital and cross-border marketing of alcohol products.

11. Other action points for the action plan

Lastly, we include these suggestions for the action plan:

- Acknowledge the need for national level alcohol policies and strategies and link them to global action plans.
- Provide financial and technical assistance to develop the capacities of state actors and non-state actors including civil society organizations on effective implementation policies and strategies.
- Scientific assessment to be done on the effect of alcohol on public health prior to entering transnational and bilateral trade policies and treaties
- Sufficient space should be provided to professional groups and civil society actors to make representation prior to entering the above-mentioned.

12. Sources

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³ McCambridge J. Mialon M. Hawkins B. Alcohol industry involvement in policymaking: a systematic review. *Addiction*, 113, 1571–1584, <https://doi.org/10.1111/add.14216>

⁴ Collin J; Ralston R; Hill SE, Westerman L (2020) Signalling Virtue, Promoting Harm: Unhealthy commodity industries and COVID-19. NCD Alliance, SPECTRUM. https://ncdalliance.org/sites/default/files/resource_files/Signalling%20Virtue%2C%20Promoting%20Harm_Sept2020_FINALv.pdf

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⁷ World Health Organization. Global status report on alcohol and health 2018. WHO 2018.

⁸ Kelsey J. How the digital age is reshaping the challenges facing alcohol policy in the trade and investment arena. Public Health and the Global Governance of Alcohol Conference, Kettil Bruun Society Thematic Meeting, Melbourne, Australia, 30 September – 3 October; 2019.

⁹ WHO EB Decision EB146(14) 7 February 2020. https://apps.who.int/gb/ebwha/pdf_files/EB146-REC1/B146_REC1-en.pdf#page=42

Foundation for a Drug-Free World (Nigeria)

Country/Location: Nigeria

URL: drugfreeworlds.org

Submission

We have a lot to conduct which include Sensitization on alcohol, what is the truth about an alcohol?, Training of trainers on the effect of alcohol and how to reduce it's effect to the society. Media public campaign against alcohol and many more.

Attachment(s): 0

Foundation for Alcohol Research and Education (FARE)

Country/Location: Australia

URL: <https://fare.org.au>

Submission

The Working Document provides a sound starting point for the development of an Action Plan.

Strengths of the Action Plan include:

- The focus on the 'Implementation of High-Impact Strategies and Interventions' or SAFER strategies
- The inclusion of global targets and indicators
- The acknowledgement of the need to increase resources required for action
- The inclusion of an objective of the need to focus on prevention and treatment being an integral part of universal health coverage.

There are also areas where the Action Plan can be strengthened, including:

1. **Prioritise actions:** Reduce and restructure the number of prioritised actions and having a greater focus on the SAFER strategies.
2. **Clarify roles:** Clarifying the role of actors, particularly ensuring that alcohol corporations and lobby groups that have a conflict of interest in financially benefiting from the sale of alcohol products are not involved in policy development.
3. **Improve governance:** Having a greater focus on governance, resourcing, review and implementation.
4. **Enhance language:** Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol'.

Attachment(s): 1

00279_52_fare-submission-global-strategy-on-alcohol-harm-feedback.pdf

10 December 2020

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organisation (WHO)
Avenue Appia 20 1211 Geneva

Dear Director-General,

Submission on the Working document of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol (Working Document).

We have reviewed the Working Document for the development of an action plan to strengthen implementation of the *Global strategy to reduce the harmful use of alcohol (Global Strategy)* and have the following comments and suggestions for your consideration.

The Foundation for Alcohol Research and Education (FARE) is a not-for-profit organisation working towards an Australia free from alcohol harms. We do this through developing evidence-informed policy, enabling people-powered advocacy and delivering health promotion campaigns. We work with people and values-aligned organisations around Australia to create change to improve our collective health and wellbeing.

Alcohol is the most used drug in Australia and it causes significant harm to the Australian community. The *'Annual Alcohol Poll 2020: Attitudes and Behaviours'* shows that 17% of Australians drink more than ten standard drinks per week, (the recommended amount in the *Australian Guidelines*). Alcohol products harms cause 5,700 deaths every year in Australia and a further 144,000 hospitalisations (*National Alcohol Indicators Project*ⁱⁱ). Alcohol products have consistently remained the most common drug of concern among people who have accessed specialist treatment servicesⁱⁱⁱ. It also contributes to other sources of harm, including road deaths and injuries, family and domestic violence and Fetal Alcohol Spectrum Disorder.

An effective Action Plan is needed to strengthen the Global Strategy

Target 3.5 of the United Nations Sustainable Development Goals 2030 includes the objective of strengthening the prevention and treatment of substance abuse, including the harmful use of alcohol. The vision behind the *2010 Global Strategy* is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to the harmful use of alcohol and the ensuing social consequences.

The implementation of the Global Strategy has been uneven across the WHO regions. Between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita. The overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, the harmful use of alcohol resulted in three million deaths worldwide. Alcohol products remain the only psychoactive and dependence-producing substance that exerts a significant impact

on global population health that is not controlled at the international level by legally-binding regulatory instruments. Without a clear Action Plan, the Global Strategy will remain unrealised and the health and economic harms of alcohol product use will remain high and continue to be an obstacle to achieving the Sustainable Development Goals.

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan.

Strengths of the Action Plan include:

- The focus on the *'Implementation of High-Impact Strategies and Interventions'* or SAFER strategies
- The inclusion of global targets and indicators
- The acknowledgement of the need to increase resources required for action
- The inclusion of an objective of the need to focus on prevention and treatment being an integral part of universal health coverage.

There are also areas where the Action Plan can be strengthened, including:

1. **Prioritise actions:** Reduce and restructure the number of prioritised actions and having a greater focus on the SAFER strategies.
2. **Clarify roles:** Clarifying the role of actors, particularly ensuring that alcohol corporations and lobby groups that have a conflict of interest in financially benefiting from the sale of alcohol products are not involved in policy development.
3. **Improve governance:** Having a greater focus on governance, resourcing, review and implementation.
4. **Enhance language:** Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol'.

Each of these areas are elaborated upon in the sections below.

1. Prioritise actions: focus on implementing high impact strategies

The Working Document rightly identifies the need to focus *'High-impact strategies and interventions'*. However, the document contains over 80 actions, which would benefit from a reduction and simplification. The Action Plan should focus primarily on the five most effective science-based interventions, or 'best buys', identified in the 'SAFER' high-impact strategies to ensure that limited resources can be used to have the greatest impact in reducing harm:

- **Strengthen** restrictions on alcohol availability.
- **Advance** and enforce drink driving counter measures.
- **Facilitate** access to screening, brief interventions and treatment.
- **Enforce** bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion.
- **Raise** prices on alcohol through excise taxes and pricing policies.

2. Clarify roles: coordinate action and limit industry involvement

The Working Document identifies many actions for each of the relevant actors (member states, WHO secretariat, partners, civil society, academia and economic operators). It also identifies *'Partnership, Dialogue and Coordination'* as an Action Area. However, it does not adequately outline the roles of each of these actors in this Action Plan. This particularly relates to the roles of a coordinating body and the role of economic operators.

Coordinating body - The WHO secretariat needs to institutionalise a permanent coordinating entity consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations.

Economic operators - The Action Plan needs more effective safeguards against alcohol industry interference. The working document refers to 'inviting' and 'encouraging' 'economic operators' (commercial interests) to abstain from policy interference and to eliminate marketing to high-risk groups. However, these requests for voluntary restraint ignore the alcohol industry's record of persistent interference and their commercial responsibilities to their shareholders. The alcohol industry should not be involved in alcohol policy development.

3. Improve governance: more regular review and reporting on progress

The indicators and milestones in the Annex 1 are helpful, however each country also needs to identify clear and objective strategies with measurable targets based on available evidence. These can then be reported at a regular (annual) alcohol policy roundtable with national leaders and civil society. The WHO Secretariat also needs to include specific timeframe for review and reporting eg. having the Director-General report biennially to World Health Assembly.

4. Enhance language: change the way that alcohol use and harm is referred to

The way that alcohol use and harm is referred to throughout the document needs to change by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.

Thank you for your consideration.

Yours sincerely



CATERINA GIORGI
CHIEF EXECUTIVE OFFICER

ⁱ NHMRC (2020) Australian guidelines to reduce health risks from drinking alcohol, <https://www.nhmrc.gov.au/health-advice/alcohol>

ⁱⁱ NDRI (2018) National Alcohol Indicators Project, <https://ndri.curtin.edu.au/publications-resources/project-reports-and-bulletins/national-alcohol-indicators-bulletins>

ⁱⁱⁱ AIHW (2020) Alcohol and other drug treatment services in Australia 2018–19, <https://www.aihw.gov.au/getmedia/44dcd395-2eb4-472c-af6e-57580c7993c4/aihw-hse-243.pdf>

Foundation for Innovative Social Development (FISD)

Department/Unit: *Alcohol, Drugs and Development (FISD)*

Country/Location: Sri Lanka

URL: www.FoundationforInnovativeSocialDevelopment.lk

Submission

We, Foundation for Innovative Social Development (FISD), Non-Governmental Organization working to prevent alcohol use and related problems, protection and promotion of the rights of the children and reduction of sexual and gender based violence in Sri Lanka. We are also a member of Sri Lanka Alcohol Policy Alliance. We closely work with FORUT International and Global Alcohol Policy Alliance. We take this opportunity express our appreciation for providing an opportunity to express our views on the working document to develop an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and congratulate you on the productive steps taken for it. FISD present the following suggestions, views and perspectives to strengthen the action plan and to make it more relevant in the context of LMICs.

Social norms and cultural Traditions

Considering alcohol use as a social norm and culturally embedded traditions prevalent in many societies implies that alcohol use as a accepted social practice in majority of societies in the world. However, even in societies where alcohol use is common and accepted it is minority of persons use most quantities of alcohol. In many other abstainers are the vast majority of people and a minority of alcohol users are tolerated even though alcohol use is not accepted as social norm. Hence, the premise that alcohol use is socially embed and culturally accepted tradition in many societies is flawed. Hence, accepting such a wrong premise would make one not to recognize these diversities and nuances in alcohol use which not monolithic. This would make one not only to fail to assess the actual situation regard to alcohol use the but also to devise effective strategy to reduce the harmful use of alcohol on the planning, enforcement, and monitoring of it.

involvement of economic operators

The involvement of the economic operators and their surrogates with the equal status quo would violate the guiding principles of the global strategy of equity-based approach and override the protect from commercial interests at the expense of public health interests. Also thwart the planning, enforcement and monitoring of the global strategy to reduce the harmful use of alcohol. The economic operators and their surrogates have unequal economic and political clout compared to other actors especially in the context of LMICs and global south, and unwise to consider that they would truly compromise their economic interest to promote public health. For example, their approaches to promote “Responsible Drinking” would be only a façade to do so in as in most societies in the world only a minority of people consume alcohol. Despite the evidence from Framework Convention on Tobacco Control suggests keeping out the economic operators and their surrogates are effective, invitation to them for in the implementation global strategy action plans need to be viewed as a “back door” entry to promote their commercial and vested interests especially in the LMICs and the global south.

Collaboration for health, policy research and accepting corporate social responsibilities from the economic operators and their social aspect public relations organisations (SAPROs) and Trade Groups will only further the poetics of the alcohol as an ordinary substance and its use as a global phenomenon for which fit for all solutions such “responsible drinking” are better than the evidence based solutions.

Marketing alcohol products to youth and children

High priority should be given to reduce the exposure of children and young people targeted appealing marketing strategies of new markets of the economic operators of alcohol in developing and low- and middle-income countries. The current low prevalence of alcohol consumption or high abstinence rates weak public policies on alcohol, greater access to satellite television and internet marketing by the economic operators with “native advertising” that is data driven and participatory should be dealt at the earliest. The cost to non-users of alcohol such as children and women and pedestrians are much more than the cost to the users. The cost to social and physical environments and SDGs are due to alcohol are equally of importance. However, lack of strict regulation to control internet based and trans-national television streaming male youth, children, women and non-users of alcohol more vulnerable to alcohol and related problems. Furthermore, in many should be considered that in many cultural traditional of alcohol are grounded in informal or small-scale production alcohol and unlike global brands does not involve commercial productions, distribution and marketing of alcohol brands, which increases the risk from harm.

Implications of Best buys/SAFER for LMICs

The implications of best buys and SAFER which are viewed as cost-effective tools for achieving the key areas for global action. However, they should be from the perspectives of the LMICs and the Global South. The emphasis of both of the above-mentioned are foisted more on the supply side dynamics of alcohol than the demand side dynamics of alcohol. Hence, Implementation of the best buys and SAFER in the context of LMIC would require considerable resource investment on which would be much challenging in the context of LMIC. As long as there exist a demand for alcohol the supply for it would exist whether legal or illegal means. Hence, the economic operators of alcohol could easily justify for increased production of alcohol while justifying easy availability as a response to reduce illicit alcohol. This could effectively annul the effects of the best buys and SAFER. Hence, the Global Action consider appropriate mixes of supply side and demand side tools such as such as awareness creations linked to be behavioral changes as group and individuals to deal with alcohol use and related problems, which are complementary to above-mentioned.

Alcohol should be viewed not as any ordinary commodity due to lack of recognition of harm, scarce technical capacity or scarce human and funding resources to deal with related problems. Hence, the action plan need to spell out steps on how to integrate into the national health priorities and policies of the member states of WHO. Also to acknowledge alcohol use is not a universal socio-culturally embedded phenomenon in most of the cultures of the world especially in the LMICs.

The “best buys” and SAFER are guidance are foisted mostly on the supply reduction approaches of alcohol control policies. While the supply reduction approaches could be more effective in developed countries with more resources for implementation, they may not be as effective in LMIC where resources are scarce. Hence, the Global Strategy should have a mix of demand reduction and supply

reduction approaches such as community-based prevention approaches and strategies which are more applicable to the context of LMICs. Furthermore, the socio-economics of alcohol and the behaviors of economic operations alcohol, licit and illicit, are not well documented and needs further investigations in the LMICs.

Taking into account the limited resource and infrastructural limitations of LMICs, effective prevention strategies through behavioural and attitudinal changes to promote alcohol free lifestyles and social milieus through community actions and empowerments should be integral part of Global Strategy for reducing harm related to alcohol use.

Monitoring and Reporting Mechanisms

Global level, national level and sub national level monitoring and reporting mechanisms on the effect on alcohol on the public health policy need to be developed and strengthened. These mechanisms should assess the effects of commercial interests and vested interests of alcohol industry and their surrogates on the public health policies and their implementations. Systematic and regular reports on alcohol use, related problems and policy gaps need to be made available at least once in 2 years. The funding priorities need to go in line with the global, national and local priorities of the alcohol use. The national alcohol policies should be synchronized with the global action plans to create synergies to reduce alcohol use and related problems. The reports should measure the accountabilities and resource mobilization to implement the action plans at the global level, national levels and sub national levels. The activities of economic operators and their surrogates should be made accountable for these and financial penalties and taxation should be used to prevent and rectify such harms.

The Global strategy should urge member states develop and implement monitoring and evaluations mechanism to collect, collage analyses and publish information and data alcohol use, related harm on the effective implementation of national policies and strategies to reduce alcohol problems.

Regulations of digital and cross-border marketing

Alcohol marketing is essential for the transnational alcohol corporations, both in its direct recruitment of drinkers and building of brand allegiance, and in normalizing alcohol use in new contexts. Alcohol marketing resources are increasingly being shifted to the digital arena, in the same way as for many other products, particularly in the social media platforms. It is becoming more evident that that traditional ways of regulating the alcohol industry and products are proving obsolete to achieve long-established public health goals in the era of social media and digitized services.

WHO Executive Board has correctly recognized and expressed deep concern that alcohol marketing, advertising and promotional activity, including through cross-border marketing, targeting youth and adolescents, influences their drinking initiation and intensity of drinking . This need to be viewed in the back drop of rapid expansion of internet and social media services in the LMICs and the targeting of the young people through these services by alcohol industry in these countries. Hence, we urge to give high priority for these issues in the action plan and make necessary resource allocations.

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Attachment(s): 0

Foundation for Rural and Urban Transformation (FoRUT)

Country/Location: Sierra Leone

URL: www.forut.sl

Submission

Emphasis on best buys/SAFER Guidelines:

The Action Plan should recognize and emphasise the WHO-led 5 most cost-effective evidence-based policies and interventions to reduce alcohol-related harm that has been packaged in the SAFEER guideline. The five SAFER focus areas (Strengthening restrictions on alcohol availability; Advancing and enforcing drink driving counter measures; Facilitating access to screening, brief interventions, and treatment; Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship, and promotion; and raising prices on alcohol through excise taxes and pricing policies) also cover the 3 best buys.

Role of economic operators:

FoRUT would like to draw state parties' attention to the interest (profit) of economic operators that does not align with the protecting public health interest. Engaging economic operators at the same level of other stakeholders will undermine public interest particularly in low- and middle-income countries (LMICs) where interference is highly likely because of the relatively less effective policy and legal environment. FoRUT therefore recommends that the Action Plan should by no means directly involve economic operators. FoRUT applauds the bold step the President of the Republic of Sierra Leone has recently taken to call for a Presidential Task Force to address the social and economic impact of alcohol. FoRUT warns against directly engaging the industries as people and profit do not mix.

Attachment(s): 1

00437_70_foundation-for-rural-and-urban-transformation-forut-statement-on-the-action-plan-to-reduce-the-harmful-use-of-alcohol.pdf

Statement from Foundation for Rural and Urban Transformation (FoRUT) on WHO consultation on the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

Foundation for Rural and Urban Transformation (FoRUT) is contributing the following points to the online consultation for the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. The action plan will ensure that member states take concrete steps to curb the health, social and economic impact of the harmful use of alcohol and reduce alcohol-related barriers to achieving the sustainable development goals. WHO released a Working document for comments from 16th November to 13th December 2020. FoRUT also urges your office to consider these issues in your own submissions.

Emphasis on best buys/SAFER Guidelines:

The Action Plan should recognize and emphasise the WHO-led 5 most cost-effective evidence-based policies and interventions to reduce alcohol-related harm that has been packaged in the SAFEER guideline. The five SAFER focus areas (Strengthening restrictions on alcohol availability; Advancing and enforcing drink driving counter measures; Facilitating access to screening, brief interventions, and treatment; Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship, and promotion; and raising prices on alcohol through excise taxes and pricing policies) also cover the 3 best buys.

Role of economic operators:

FoRUT would like to draw state parties' attention to the interest (profit) of economic operators that does not align with the protecting public health interest. Engaging economic operators at the same level of other stakeholders will undermine public interest particularly in low- and middle-income countries (LMICs) where interference is highly likely because of the relatively less effective policy and legal environment. FoRUT therefore recommends that the Action Plan should by no means directly involve economic operators. FoRUT applauds the bold step the President of the Republic of Sierra Leone has recently taken to call for a Presidential Task Force to address the social and economic impact of alcohol. FoRUT warns against directly engaging the industries as people and profit do not mix.

13th December 2020

Foundation for Rural and Urban Transformation (FoRUT)

Foundation for Social Welfare Services

Department/Unit: *Agency Sedqa*

Country/Location: Malta

URL: <https://fsws.gov.mt/en/sedqa/Pages/welcome-sedqa.aspx>

Submission

The Working Document for the Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful use of Alcohol is generally very good.

It has put in place percentile parameters that will guide WHO to clearly assess the general trends of countries in implementing suggested Policies. With clear guideline it also helps countries to set their own parameters for improvements that can be obtained from data, they themselves send to WHO.

Notwithstanding this, the document still lacks into giving some regional objectives in a way that it could see an alignment of policies in specific areas. This leaves the countries in each and every region the space to adopt an action plan to its liking, if any. Whilst respecting the country's sovereignty to decide on its national alcohol policy, this leaves margin for policy biases that leaves room for progress of one country's implementation being jeopardised by bordering countries that allow for less strict regulations. This in turn affects the overall result of the WHO Region itself.

Attachment(s): 0

Foundation for the Advancement of Liberty

Country/Location: Spain

URL: www.fundalib.org

Submission

Please see the attached document, which opposes the Action Plan and the Global Strategy on economic and individual liberty grounds.

Attachment(s): 1

00120_09_response-to-the-who-on-the-alcohol-action-plan.pdf



To the World Health Organization (WHO)

A response to the Working Document for Development of an Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

01. Introduction. By submitting this response document, the Foundation for the Advancement of Liberty, a think tank and policy research and advocacy institution based in Madrid, Spain, wishes to convey its position to the World Health Organization on the Action Plan and, furthermore, on the Global Strategy itself. The Foundation is completely opposed to both, and this document aims at making the case against them.

02. The WHO. The WHO is an international organization, its members being therefore sovereign states. While the Foundation considers it wise for national governments to participate in such entities in order to exchange policies, opinions and information, and to discuss global matters, it also rejects the idea that these organizations should promote particular policies to be implemented by their member states. Very often, the conclusions and recommendations adopted by these entities are used by national governments as a way to force particular policies onto their population, thus undermining the social and political debate and due decision making processes by the country's institutions. Resorting to push for a certain policy with the heavy leverage of its "international legitimacy" is in fact government overreach, and the organizations in the UN System are often complicit to this undemocratic practice, while also incurring themselves in the same type of overreach towards many weaker member states which may not wish to follow the general consensus, but are compelled to comply.

Therefore, the Foundation, in taking part in this consultative process, asks the WHO to limit itself to play the legitimate role of a policy exchange and discussion forum, rather than that of a policy making body whose decisions are presented as a sort of mandate to be followed suit by the international community.

03. The concept of "Accelerating Action". Related to item 02 above, EB146(14) agenda item 7.2. requested the Director-General to develop an action plan to "effectively implement the global strategy". While this wording may just be exaggerated, the intention behind it is clearly that of adopting a sort of supranational policy which countries should abide by. The very concept of "accelerating action" is of an executive nature and thus, in the Foundation's view, severely overreaches the role of international organizations such as the WHO and instead invades its member states' sovereignty and their decision making processes.

04. Misuse of taxpayer money. Request No. 3 in the original Executive Board document called for "adequate" funding of the work related to the harmful use of alcohol. In fact, this funding comes from the hard efforts of the member states' taxpayers. Many of those taxpayers are actually people who may disagree with the purposes of the work to be carried out. Furthermore, many of these taxpayers are companies and individuals in the alcohol industry and related industries. Therefore this request amounts to making the member states force their taxpayers to fund a "resource work" that may in fact be detrimental to their own personal or business interests or to their views and opinions. In so doing, the WHO incurs in a severe loss of neutrality and attacks the sources of income of millions of people worldwide.

05. Damage to the economy and several industries. As a Spanish Foundation, we focus on the damage the Action Plan and the Global Strategy will undeniably cause to Spain's economy, However, we believe this damage to be equally relevant in many other countries. Just like most other social engineering attempts derived from interventionistic thinking, this strategy fails to see the ramifications of the proposed action. These do not end in the industries producing alcoholic drinks.

The alcohol beverage industry alone accounts for around twenty billion euros in volume of business in Spain, and yet this is relatively small compared to the connected activities of the restaurant and leisure industries and, especially, tourism. Tourism accounts for 14.6% of Spain's GDP. Following the WHO's Global Strategy would be a disaster for an economy like ours, and pushing for its "acceleration" in this particular moment in time, when the Spanish economy is devastated by the Covid-19 pandemic, would be a terminal blow to Spain's economy. It is necessary to mention that our country has the highest rates of general and youth unemployment in the developed world, and it cannot afford to lose a very high number of jobs in the alcohol and related industries. A particular damage would be inflicted to Spain's wine industry. Suffice it to say that this industry's exports are over 1.8 billion euros per year, and they are thus crucial to the country's foreign trade figures.

06. Damage to freedom. The WHO's Global Strategy on alcohol, like so many other attacks on the consumption of certain types of substances (whether legal or illegal), is a blow on the fundamental right to individual freedom. Social engineering by national governments, too often with the excuse of "internationally sanctioned" policies adopted by the UN System's organizations, aims at diminishing the individual's sovereignty over his or her own body. We have seen the devastating effects of wrong policies like the state control of antibiotics, the failed war on drugs, or the attacks on (still) legal tobacco or various types of food, like sugar, carbonated beverages or some types of fat. This time around, it is alcohol the WHO targets. But considering the WHO's eagerness to harness the individuals and their consumption, tomorrow it may well be anything else.

Alcohol drinks are a part of Spain's and many other countries' culture, including interpersonal relations, socializing, leisure activities and cuisine. The WHO pretends to only attack the "harmful use" of alcohol, but it is not up to any national or global political entity to decide how much or which type is "harmful" and to then impose its standards onto the individual. The body is the sole possession of its inhabitant. It is up to him or her to decide on how to use it, including how much or what kind of alcohol to consume. The state is not his or her parent, and has no authority whatsoever on his or her body. Policies such as the ones envisaged by the Global Strategy are therefore an invasive interference which threatens the individual's management of his or her most precious property.

Finally, the Executive Board called on the Director-General to target marketing, advertising and promotional activities related to alcoholic beverages. This is again an intolerable aggression to freedom, this time particularly targeting freedom of expression and free trade. Also, this attack on the advertising industry and its companies and employees is yet another proof that the Global Strategy does not address truly abusive use of alcohol, but targets alcohol generally and thus aims at diminishing its public presence and its trade.

07. The Foundation's conclusion and action. For the reasons explained above, the Foundation asks the World Health Organization's bodies and its member states to countermand the Director-General and to stop the Action Plan and any other initiatives in pursuance of the Global Strategy, and to cancel the said strategy. Furthermore, the Foundation will join forces with any other private institutions in Spain and elsewhere to fight the WHO's policy and to call upon governments not to enforce them and upon businesses and the people to disobey.

Madrid, November 30th, 2020

For and on behalf of the Foundation for the Advancement of Liberty,



Juan Pina, Secretary-General

Fourth Wave Foundation

Department/Unit: *Project VENDA*

Country/Location: India

URL: www.fourthwavefoundation.org

Submission

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition
2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
4. Ensure a greater focus on SAFER strategies;
5. Ensure greater focus on governance and infrastructure improvements;
6. Improve resourcing as well as reporting and review of implementation; and
7. Update nomenclature in line with state-of-the-art evidence.

B. Additional point to be added to the action plan

1. Suggestion for elements of the action plan

C. Point of criticism and request for significant change

1. Role of the alcohol industry, conflict of interest

Attachment(s): 1

00463_88_movendi-members-who-workingdoc-consultation.pdf



Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

Fourth Wave Foundation grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

The Fourth Wave Foundation exists to catalyse social change by innovating and piloting model solutions that Governments and implementing agencies can replicate using our technical knowledge, in-depth understanding of the challenges and unique insights gleaned from almost two decades of dedicated work. Project VENDA, an initiative of Fourth Wave Foundation works dedicatedly to contain substance abuse and drug addiction in Kerala, We empower children and young adults to say NO to drugs and stay away from dangers like alcohol, social network misuse, pornography, sexual abuse and technology addiction, by helping them channel their energies into creative pursuits, creating awareness on substance abuse, counselling and facilitating rehabilitation. We equip parents, teachers, doctors, heads of institutions and other stakeholders create a safe, drug-free environment for children and empower them to live purposefully.

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

- A. 7 Points for Action Plan Improvement
 1. Ensure bold targets and ambition
 2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
 3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
 4. Ensure greater focus on the SAFER strategies;

5. Ensure greater focus on governance and infrastructure improvements;
6. Improve resourcing as well as reporting and review of implementation; and
7. Update nomenclature in line with state-of-the-art evidence.

B. Additional point to be added to the action plan

1. Suggestion for elements of the action plan

C. Point of criticism and request for significant change

1. Role of the alcohol industry, conflict of interest

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome – and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world's children. The WHO–UNICEF–Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children's health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and

- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

Where possible, actions and key indicators should be time-bound.

4. Ensuring greater focus on the SAFER strategies

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions – to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol.

We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys – that has largely fallen short of necessity – is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document.

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements – learning lessons from other health areas.

Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.

2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.
7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings – like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals – like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO’s expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

Regarding the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called “Infrastructure”.

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential – as tobacco control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden.

For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level.

We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through "SAFER pilot countries".

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial – both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets

2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.

3. Framework for action

Operational objectives: 8

Priority areas for global action: 6

Global action: WHO

National action: Member States

4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Free Market Foundation

Country/Location: Hungary

Submission

Although the WHO's intention's to reduce the harmful use of alcohol must be lauded, the working document misses the mark, and does not give this good intention a pragmatic structure.

The document fails to properly justify its proposals, fails to recognize that the issue is more nuanced and thus merits a more intricate and detailed approach than the one-size-fits-all measures it puts forth.

Due to the document's shortcomings in distinguishing between various degrees in which alcohol is consumed, the aim of the document is lost in feel-good suggestions rather than carefully considered recommendations that duly serve the purpose of reducing harmful consumption.

Given these oversights, which lend the document the appearance of being rushed, the unintended consequences of the policies are not factored in, raising serious questions about the net benefits thereof.

Attachment(s): 1

00465_03_who-consultation-by-free-market-foundation.pdf

Introduction

Although the WHO's intention's to reduce the harmful use of alcohol must be lauded, the working document misses the mark, and does not give this good intention a pragmatic structure.

The document fails to properly justify its proposals, fails to recognize that the issue is more nuanced and thus merits a more intricate and detailed approach than the one-size-fits-all measures it puts forth.

Due to the document's shortcomings in distinguishing between various degrees in which alcohol is consumed, the aim of the document is lost in feel-good suggestions rather than carefully considered recommendations that duly serve the purpose of reducing harmful consumption.

Given these oversights, which lend the document the appearance of being rushed, the unintended consequences of the policies are not factored in, raising serious questions about the net benefits thereof.

Supply and demand

The justification of the working document is that implementation of the Global Strategy to Reduce the Harmful Use of Alcohol should be strengthened, but it fails to reason as to why. It mentions that "Between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita [...]" but then goes on claiming that "The number of drinkers declined across all WHO regions between 2010 and 2016." Although it distinguishes between the different trends in the various regions, from which the logical conclusion would be to have tailor made approaches, the document proposes one-size-fits-all policies. It also fails to distinguish between heavy and light and moderate drinkers.

The document focuses entirely on reducing the supply of alcohol, even for those who are not heavy drinkers despite recognizing that heavy episodic drinking dwindled (undermining the existence of the document) and that different regions have different trends. "Age-standardized prevalence of heavy episodic drinking (defined as 60 or more grams of pure alcohol on at least one occasion at least once per month) decreased globally from 20.6% in 2010 to 18.5% in 2016 among the total population but remained high among drinkers, particularly in parts of Eastern Europe and in some sub-Saharan African countries (more than 60% among current drinkers)."

(World Health Organisation (2020) Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. 14 November. Page 2.)

The document rightly recognizes that substance abuse is comorbid with other mental illnesses and there is often a cause and effect relation, but focuses solely on mental

health issues caused by alcohol abuse, not recognizing it can also be the other way around.

“This reflects the broader impact of harmful alcohol use on health beyond NCDs – in areas such as mental health, violence, road traffic injuries and infectious diseases.” (*World Health Organisation (2020) Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. 14 November. Page 2.*)

While the aim to reduce mental health issues by tackling the issue of harmful alcohol consumption is admirable, and if definitely a factor to consider, however the document fails to mention that mental health issues can also lead to alcohol abuse. Almost a quarter of those who have mood and anxiety disorders self medicate with alcohol and/or drugs. (Turner, S., Mota, N., Bolton, J., & Sareen, J. (2018). *Self-medication with alcohol or drugs for mood and anxiety disorders: A narrative review of the epidemiological literature. Depression and anxiety, 35(9), 851–860.* <https://doi.org/10.1002/da.22771>)

Diminishing the supply of alcohol will not solve the underlying problem. Focusing on advertisement bans, and price increases through taxes , as the SAFER initiative proposes will not affect the demand. While maybe it will affect legal alcohol purchases, the illicit alcohol trade will increase, as also recognized by the Global Strategy: “Furthermore, restrictions on availability that are too strict may promote the development of a parallel illicit market.” (*World Health Organisation (2010) Global strategy to reduce the harmful use of alcohol. Page 14.*)

The demand for the effects of alcohol will not change by tampering with the supply. If alcohol will not be available, substitutes will be found. According to an Australian study “Higher alcohol prices resulted in increased consideration of illicit substances as an alternative indicating a substitution effect [...]” (Peter G Miller, Nicolas Droste (2013) *Alcohol Price Considerations on Alcohol and Illicit Drug Use in University Students. Journal of J Alcoholism & Drug Dependence, 2013, 1:2 DOI: 10.4172/2329-6488.1000109*)

The working document thus fails to look at the bigger picture and recognize unintended consequences. It also fails to concentrate on the demand side of harmful alcohol consumption. For instance the document does not consider socioeconomic factors. Heavy drinking is more prevalent among low income people. (Cerdá, M., Johnson-Lawrence, V. D., & Galea, S. (2011). Lifetime income patterns and alcohol consumption: investigating the association between long- and short-term income trajectories and drinking. *Social science & medicine (1982), 73(8), 1178–1185.* <https://doi.org/10.1016/j.socscimed.2011.07.025>)

The answer therefore would be not to increase alcohol prices but to focus on tackling a more complex socioeconomic problem.

Conclusion

Unfortunately the working document oversimplifies an existing problem and thus fails to provide adequate suggestions of response. Rather than finding nuances between alcohol consumers, and differences in regions it proposes blanket measures that might not work for all. It also focuses on cheap rather than effective measures as constantly stressed during the document. These measures will have unintended consequences such as an increase in illicit alcohol trade and an increase in other substance abuses. The document focuses on supply for all consumers rather than aiming to reduce demand for heavy drinking.

Free Trade Europa

Country/Location: Sweden

URL: <https://freetradeeuropa.eu/>

Submission

Issues related to the harmful use of alcohol must be taken seriously and addressed, yet a sense of perspective and realism is also needed. Rates of alcohol consumption are dropping across Europe - particularly among the young - while incidences of binge-drinking and drink-driving are also falling. At the same time, the number of Europeans who are teetotal is rising.

It is also vital that the WHO does not ignore the huge economic, cultural and societal importance of the alcohol sector for Europe. In this submission, we also highlight the impact of COVID-19 and underline the ineffectiveness of higher taxes and prohibition on alcohol consumption. The answer instead lies in increased education, allowing personal choice and tackling the root causes of substance abuse.

Attachment(s): 1

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THE RIGHT APPROACH TO ALCOHOL

WHO consultation on a working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol



 Free Trade Europa

Free Trade Europa submission to the WHO consultation on a working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol

November 2020

We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration.

Summary

Issues related to the harmful use of alcohol must be taken seriously and addressed, yet a sense of perspective and realism is also needed. Rates of alcohol consumption are dropping across Europe - particularly among the young - while incidences of binge-drinking and drink-driving are also falling. At the same time, the number of Europeans who are teetotal is rising.

It is also vital that the WHO does not ignore the huge economic, cultural and societal importance of the alcohol sector for Europe. In this submission, we also highlight the impact of COVID-19 and underline the ineffectiveness of higher taxes and prohibition on alcohol consumption. The answer instead lies in increased education, allowing personal choice and tackling the root causes of substance abuse.

Ignoring the facts

Calls for a stricter approach to alcohol appear to be unrelated to the reality in Europe. Rates of alcohol consumption have steadily fallen over the past century, particularly among the young. The WHO's own report¹ found that weekly drinking decreased significantly between 2002 and 2014 for boys and girls in most European countries and regions. In addition, a study for BMC Public Health² found that 25% of young people (16-24 year olds) in England identified as being a "non drinker".

¹ https://www.euro.who.int/_data/assets/pdf_file/0007/382840/WH15-alcohol-report-eng.pdf Adolescent alcohol-related behaviours: trends and inequalities in the WHO European Region, 2002–2014. World Health Organization. (2018)

² <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-018-5995-3> Investigating the growing trend of non-drinking among young people; analysis of repeated cross-sectional surveys in England 2005–2015. 2018.

In addition, rates of heavy episodic drinking - commonly referred to as binge drinking - have decreased rapidly in recent years. An International Alliance for Responsible Drinking (IARD) report highlights that binge drinking among Europeans aged between 20 and 24-years-old fell by almost a quarter (23%) between 2005 and 2016³.

Furthermore, cases of drink-driving are falling too. A study for ETSC highlighted that road deaths attributed to alcohol were cut by 47% between 2006 and 2016 in the EU25⁴. Furthermore, attitudes in Europe have changed. Politicians, personalities and celebrities who are caught drink-driving are rightfully vilified by the media, and in public opinion, as it is no longer socially acceptable⁵.

The economic and cultural dimension

Alcohol also has a vital cultural significance. Enjoyed responsibly, it is a significant part of daily life in many countries. The local pub is a cornerstone of village and city life in the UK and Ireland while Nordic residents could not imagine a Midsummer or Christmas celebration without a few glasses of schnapps. In the same vein, Champagne and Bordeaux wines are a vital part of the social, historical and economic fabric of life in parts of North East and South West France, respectively, in the same way that whisky is for the Highlands of Scotland.

The alcohol industry is also of importance economically. In Europe, wine growing makes up 15% of France's agricultural revenues - with exports totaling EUR 8.3 billion in 2015 - and provides 600,000 jobs⁶. In Italy, 7.56 billion bottles of wine were produced in 2018⁷ while the value of the wine industry is EUR 10 billion⁸. Similarly, the Scotch whisky industry contributed 21% to the value of all UK food and drink exports. Exports were worth GBP 4.7bn. The industry also supports 42,000 jobs, including 10,500 directly employed in Scotland and 7,000 in rural

3

<https://iard.org/getattachment/ac5eaa00-c6fa-4fb1-b285-832358db2794/trends-report-heavy-episodic-drinking-2019.pdf> Trends Report: Heavy Episodic Drinking. International Alliance for Responsible Drinking (IARD) (2019)

4 https://etsc.eu/wp-content/uploads/report_reducing_drink_driving_final.pdf PROGRESS IN REDUCING DRINK DRIVING IN EUROPE (February 2018).

5 <https://www.dn.se/nyheter/politik/aida-hadzialic-avgar-som-minister-efter-rattfylla/> Swedish Minister Aida Hadzialic resigns after being caught drink driving. Dagens Nyheter. (August 2016).

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https://www.businessfrance.fr/Media/Default/PROCOM/Kits/Agroalimentaire/Business_France-Wine_Industry.pdf French Wine Industry. Business France (2019).

7 <https://www.amfori.org/sites/default/files/amfori-2020-02-12-Brochure-Italian-Wine-Industry.pdf> AMFORI figures.

8 <https://www.statista.com/forecasts/393106/manufacture-of-wine-from-grape-revenue-in-italy> Industry revenue of "manufacture of wine from grape" in Italy from 2012 to 2024. Statista. (2020).

areas⁹. Added to this is the huge tax revenues that the sector already provides to state coffers which pay for schools, hospitals and other vital services across Europe.

The impact of Covid-19

The Coronavirus pandemic is inevitably causing a number of societal problems. Difficult times mean increased stress and worry about loved ones, job losses and enforced restrictions on account of new measures and national lockdowns across Europe. While calls and online requests to national domestic abuse helplines, for example, are up dramatically, rates of alcohol abuse are not rising.

Social contact is important for mental well-being and is a proven antidote to depression. People should not feel guilty and be stigmatised if they meet friends for a drink or enjoy an aperitif while they have a group chat with family and friends over Zoom or Skype. Moderation is crucial and having a small tippie does not pose a problem for the vast majority of the population. Recent studies actually show that it is good for people in later life to have a drink once per day¹⁰.

While alcohol sales went up in March 2020, this had more to do with stockpiling and panic buying, than Europe becoming a continent of dipsomaniacs. Toilet rolls, cans of tuna fish and boxes of pasta were being hoarded at a similar rate. To back this up, there is no evidence to suggest that all those supplies were being consumed. On the contrary, social media is full of "DryCovid" references while a study by UCL University¹¹ in Belgium shows no general increase in alcohol consumption during COVID-19 related lockdowns. 29% of respondents actually reported they were drinking less than before the lockdown.

In sum, with many populations locked down and self-isolating, all forms of drinking are actually less common and this is a trend that has been steadily declining well before the Coronavirus pandemic hit.

"No" to prohibition and higher taxes. "Yes" to education and personal choice

History clearly shows that excessively high taxes and prohibition do not work in controlling alcohol consumption. Instead, consumers turn to illegal channels - depriving national treasuries of tax revenue - and in turn expose themselves to further health risks. Higher taxes, or prohibition, would increase the illegal sale of alcohol products which do not meet the

⁹ Centre for Economic and Business Research figures for the Scotch Whisky Association.

¹⁰ <https://academic.oup.com/ageing/article/48/1/134/4992693> Drinking in later life: a systematic review and thematic synthesis of qualitative studies exploring older people's perceptions and experiences. Age and Ageing. Oxford Academic. Volume 48, Issue 1, (2019)

¹¹ <https://uclouvain.be/fr/decouvrir/presse/actualites/consommation-d-alcool-stable-voire-en-baisse.html> Consommation d'alcool stable. UCLouvain. (2020).

standards set or the applicable laws in Europe. Similarly, home-brewing will also increase which may also lead to injury and even deaths.

A more sensible approach is for the WHO to advocate education, building knowledge about enjoying alcohol responsibly and allowing Europeans to make their own decisions.

Realistic on alcohol; tough on alcohol abuse and the causes of alcohol abuse

By way of a conclusion, the overall message of the WHO should be consistent: enjoy alcohol responsibly. Using alcohol as part of a coping strategy, however, is extremely bad and should be avoided. Anyone exceeding the weekly recommended alcohol intake limit - or who is self-medicating - should seek help. This is where the WHO, national governments and industry can work together to support those who have a problem with alcohol. It is equally vital for the WHO, politicians and other stakeholders to focus on addressing the underlying causes of addiction and substance abuse, rather than purely focusing on one part of it.

Freedom Research Association

Country/Location: Turkey

URL: www.oad.org.tr

Submission

Death Rates Increase Because of Higher Alcohol Prices

As the government of Turkey pushes up the price of alcoholic drinks, many Turkish people are turning to homemade hooch – depriving the state of tax revenue, and sometimes suffering fatal consequences.

The latest annual report of the Turkish Court of Accounts, published on October 4, showed that consumption of alcoholic drinks fell by a whopping 25 per cent in 2019 alone, because of higher taxes. However, the same report shows that more people are producing their own alcoholic beverages at home with special kits and flavours, as well as with ethyl alcohol, or ethanol, which is sold online and by pharmacies for medical purposes.

Consumers have increasingly decided to produce their own alcoholic beverages in their homes since 2013. Its figures show that sales of ethyl alcohol rose by nearly 450 per cent between 2013 and 2019. In 2019, 7.75 million litres of ethyl alcohol was sold, only 1.5 million of which was used for medical purposes; the rest was used to produce unregistered alcoholic beverages.

Due to its low cost, bootleg alcohol made with methyl alcohol instead of ethyl alcohol causes serious harm to human health, as well as deaths. Illegally produced liquor is often laced with methanol, which can cause permanent blindness, metabolic disturbances, and death. In the October, at least 45 people in Turkey have died after consuming illegally produced unregistered alcoholic beverages in several cities. 50 people are in hospital intensive care units for the same reason. Turkish police found out that the reason for deaths is that people were using ethyl alcohol-based hand disinfectants for making alcoholic beverages. The average death rates due to illegal produced liquor were 32 people per year but after the 2019 tax increases on alcohol, 89 people have died from January 2020 to October 2020.

Nationwide raids against producers have increased in the country since the beginning of 2020. As many as 418 suspects have been held in operations and 93 of them have been remanded in custody. The police seized 1,305 liters of ethyl alcohol and other materials used in alcohol production and 8,840 liters of bootleg alcohol in just one month. This new trend also means the state lost 1.56 million lira that year, equal to about 170 million euros, in tax revenue.

Attachment(s): 1

00418_58_alcohol-legislation-turkey.pdf

ALCOHOL CONSUMPTION RATES AND LEGISLATION IN TURKEY

İsrafil ÖZKAN*

Alcohol Consumption Rates in Turkey

Turkey ranks last among European countries and last among Organization for Economic Co-operation and Development (OECD) member countries in terms of per capita alcohol consumption rates, estimated at around 1.5-1.6 liters per person per year. Turkey also ranks low on the world list of per capita alcohol consumption, well behind the world average. Also Turkey ranks lowest among countries worldwide in terms of years of life lost due to alcohol, according to the WHO Global Alcohol Status Report, 2018 between 2010 and 2016.

Alcohol Legislation

Law No. 4250 on Alcohol and Alcoholic Beverages, as well as the Regulation on the Procedures and Principles of the Sale and Marketing of Tobacco Products and Alcoholic Beverages, prohibits every type of advertisement and presentation of alcoholic beverages, prohibits campaigns, promotions, and any activity that encourages the consumption and sale of alcoholic beverages in any kind of media.

- Total ban on all forms of advertising including on TV and radio, ads in the cinema, product placement, printed media, etc., as well as social media and any digital platform.
- Ban on trademark logo and alcohol brand sign placements at points of sale, sales units, refrigerators, and coolers, any other portable and stable materials. With exceptions for service materials used to serve alcohol in restaurants and cafes that have licenses to serve alcoholic beverages, such as glass, corkscrews etc., but not common material such as plates, tablecloths. Except for products intended for export, all packaging should include warning labels.
- Alcoholic beverage manufacturers, importers and marketers cannot support or sponsor any activity by using the brand, logo, or sign of their products. If an alcohol company sponsors any activity they can only use the company name.
- Producers, exporters, and marketers of alcoholic beverages, regardless of the purpose, cannot give alcoholic beverages as promotions, gifts, or for free.
- Brand stretching is prohibited. Names, brands and other distinctive elements of alcoholic beverages cannot be used on non-alcoholic products nor any other products. The sale of alcohol through automatic vending machines and mail order is prohibited.
- The retail sales between 10pm and 6am is prohibited.
- The sale of alcohol within 100 meters of schools and mosques is prohibited. Alcoholic beverages cannot be sold or consumed in most facilities on motorways and public highways, in addition to student dormitories, stadiums, indoor sport halls, educational institutions, gas stations, and health facilities.
- The law imposes fines for violations. The amount depends on which rules are broken, and this is specified in the text of the law.
- The alcohol limit for drivers of private vehicles is 0.05 percent, reduced from 0.1 percent. Violation of the legal limit is punishable by fines and a six-month driving ban.

Tax Increases on Alcohol Prices

As part of the effort to curb alcohol consumption rates and cut down on underage drinking, the government of Turkey has introduced several tax increases on alcohol. Special consumption taxes (SCT) have been increased or adjusted regularly, around every six months, leading to an increase in cost for most alcoholic drinks. According to Eurostat data, Turkey has the 3rd most expensive alcohol price in Europe and the 6th most expensive in the world. The reason for the high prices is taxes. The sales price of 70 raki (traditional Turkish alcohol beverage) is 160 Turkish Lira (TL) today, the %70.2 (112 TL) of this sale price is SCT. Before the SCT, the price of raki of the same scale in 2002 was 8.25 lira.

The increase in prices of an average raki was only slightly higher than the regular inflation, 204% to 206%, from 2003 when Justice and Development Party (AKP) came into the office until 2012. However, between 2013 and 2020, the average price of raki has far more exceeded the inflation of commodity prices, 359% to 213%, due to the high tax rates.

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This new trend also means the state lost 1.56 million lira that year, equal to about 170 million euros, in tax revenue.

*** İsrail ÖZKAN**
Executive Director
Freedom Research Association (www.oad.org.tr)
Ankara/Turkey

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French Association of Wine and Spirits Exporters (FEVS)

Country/Location: France

Submission

FEVS (French Association of Wines and Spirits Exporters) is the professional organization representing the interests of companies exporting French wines and spirits. It brings together 550 companies, mainly SMEs, which account for 85% of French exports of wines and spirits.

FEVS shares and supports the commitment of the entire alcoholic beverage sector to fight against alcohol abuse. Then, FEVS thanks the World Health Organization (WHO) for the opportunity to contribute to this objective by providing its comments on the "Draft action plan".

The 146th Executive Board of WHO confirmed the validity and relevance of the 2010 Global Strategy to reduce the harmful use of alcohol (GSA) and ask for an action plan which aims "to effectively implement the Global Strategy as a public health priority". As a consequence, FEVS considers that the content of the action plan has to be fully consistent with the objectives and principles of the 2010 WHO GSA. This especially means the action plan should:

1. focus exclusively on the harmful use of alcohol,
2. continue to provide a menu of options to Member States,
3. acknowledge and support commitment from economic operators in implementing the GAS,
4. not include proposals that are clearly contrary or extraneous to it.

The WHO action plan should also acknowledge and support recommendations and principles adopted by other international organisations (like WTO, OIV...) which contribute to the reduction of alcohol misuse rather than seeking to define new standards by its own.

Lastly, FEVS would like to encourage WHO to fully value, through the action plan, the commitments and results obtained by every stakeholder (State, scientists, NGOs, private sector...) as an incentive to increase and strengthen the collective effort in reducing the harmful use of alcohol.

Attachment(s): 1

00448_79_20201210-contribution-fevs-consultation-oms-sur-projet-plan-d-action.pdf

**CONTRIBUTION DE LA FEVS A LA CONSULTATION DE L'OMS SUR LE PROJET DE PLAN D'ACTION
RELATIF A LA STRATEGIE MONDIALE DE LUTTE CONTRE L'USAGE NOCIF DE L'ALCOOL**

10 Décembre 2020

La Fédération des Exportateurs de Vins et Spiritueux de France (FEVS) est l'organisation professionnelle représentative des intérêts des entreprises exportatrices de vins et spiritueux français. Elle rassemble 550 entreprises, dont une très grande majorité de petites et moyennes entreprises, qui comptent pour 85% des exportations françaises de vins et spiritueux en valeur.

La FEVS suit avec attention l'ensemble des sujets et débats internationaux ayant trait à la consommation et au commerce des vins et spiritueux, y inclus les interactions entre alcool et santé publique. A ce titre, la FEVS partage et soutient l'engagement de l'ensemble du secteur des boissons alcoolisées pour lutter contre la consommation abusive d'alcool.

La FEVS tient ainsi à remercier l'Organisation Mondiale de la Santé (OMS) pour lui donner la possibilité de contribuer à cet objectif en faisant part de ses commentaires dans le cadre de la consultation publique sur le « *Projet de plan d'action destiné au renforcement de la mise en œuvre de la Stratégie mondiale de lutte contre l'usage nocif de l'alcool* ».

Comme souligné dans le document soumis à consultation, le futur plan d'action vise à répondre à la demande du 146^{ème} Conseil exécutif de l'OMS. A l'issue d'un processus d'évaluation et de consultation des parties prenantes réalisé en 2019-2020, le Conseil exécutif a en effet « *[constaté] que la Stratégie mondiale visant à réduire l'usage nocif de l'alcool conserve toute sa pertinence [tout en] observant que les ressources et les capacités pour sa mise en œuvre au Secrétariat de l'OMS et dans certains États Membres ne sont pas en rapport avec l'ampleur des problèmes* ». Le plan d'action a ainsi pour objectif de « *mettre effectivement en œuvre la Stratégie mondiale visant à réduire l'usage nocif de l'alcool en tant que priorité de santé publique* » ([Décision EB\(146\)14 du 7 février 2020](#)).

En conséquence, la FEVS tient à souligner que le contenu du plan d'action doit s'inscrire, dans son intégralité, en complète cohérence avec les objectifs, principes et dispositions contenus dans la Stratégie mondiale de l'OMS telle qu'adoptée en 2010.

- **Le plan d'action doit viser uniquement l'usage nocif de l'alcool.** Comme le montre le projet de plan d'action, il n'y a pas de corrélation, pour un pays donné, entre le niveau de consommation moyenne par habitant et le niveau de consommation nocive (voir p.3). Ceci est lié aux normes culturelles, sociales ou religieuses, à l'environnement socio-économique, aux comportements de consommation et aux politiques mises en place qui influencent chacun de ces deux facteurs. A titre d'exemple, en France, qui fait partie des pays ayant la consommation moyenne par habitant la plus élevée d'Europe, près de 90% des consommateurs d'alcool respectent les recommandations des pouvoirs publics en matière de consommation responsable.¹

¹ Voir http://beh.santepubliquefrance.fr/beh/2019/5-6/pdf/2019_5-6.pdf (p.89)

Ainsi, l'« Action Area 1 » devrait se concentrer exclusivement sur l'usage nocif de l'alcool, et ne pas contenir d'actions ou d'indicateur ciblant spécifiquement la baisse de la consommation d'alcool moyenne par habitant (voir Global Target 1.2).

- **Le plan d'action doit continuer de promouvoir un menu d'options à la disposition des Etats.** La capacité des Etats à adapter leurs actions au contexte socio-économique et culturel, aux ressources disponibles, à leur environnement réglementaire et aux tendances de consommation de long terme est un élément-clé de la Stratégie mondiale. Elle conditionne l'efficacité et l'efficacité des politiques publiques de lutte contre l'usage nocif de l'alcool.

A l'inverse, le projet de plan d'action semble vouloir faire de SAFER la solution unique (*one size fits all solution*) d'une mise en œuvre renforcée de la Stratégie mondiale (voir Action Area 1).

Or, tant les études scientifiques que les faits montrent qu'il n'existe pas de corrélation entre l'application des mesures contenues dans SAFER et l'évolution des comportements de consommation. A titre d'illustration, en Europe, les pays présentant les scores les plus élevés de mise en œuvre des « *best buys* » sont, dans l'ordre décroissant, la Suède, la France et l'Italie (à égalité avec Portugal et Finlande), soit cinq pays présentant des niveaux de consommation moyenne, de consommation abusive et des tendances d'évolution particulièrement différents.²

De plus, plusieurs facteurs peuvent venir diminuer l'efficacité attendue des mesures proposées dans SAFER, voire créer des effets secondaires négatifs, limitant ainsi la pertinence de cet outil pour de nombreux Etats membres, notamment : une forte clientèle touristique étrangère, une facilité d'achats d'alcool transfrontaliers, une porosité entre le marché régulé et la production illégale ou non-déclarée (*home made*) d'alcool.

Ainsi, le plan d'action devrait plutôt soutenir les Etats membres dans la mise en place des actions qui leur semblent pertinentes plutôt que de vouloir faire de SAFER le baromètre unique de la Stratégie de 2010 (voir Global Target 1.1) ; et ce, d'autant plus que SAFER reste un outil technique qui n'a pas été adopté par les Etats membres de l'OMS contrairement à ce que laisse penser le document.

- **Le plan d'action doit reconnaître et encourager les opérateurs économiques à être partie prenante de la mise en œuvre de la Stratégie mondiale contre l'usage nocif de l'alcool.** Reconnu dès l'adoption de la Stratégie en 2010, le rôle des acteurs économiques a été confirmé par l'Assemblée générale des Nations Unies en octobre 2018 dans le cadre de la Déclaration politique de la 3^{ème} réunion à haut niveau sur les maladies non-transmissibles (voir §44 b) et c))³.

Si le projet de plan d'action contient effectivement des propositions d'action pour les représentants du secteur privé, ces derniers sont néanmoins présentés comme ayant par nature un conflit d'intérêt avec les objectifs de la Stratégie mondiale, voire considérés comme un obstacle à sa réalisation. Les opérateurs économiques sont ainsi traités de façon différenciée et isolée, alors même que la réussite des actions passe, comme le reconnaît le document, par les partenariats et une approche inclusive (*whole-of-society approach*).

Or, notre secteur s'investit, tant au niveau national qu'international dans les actions et programmes visant à réduire les consommations nocives. A titre d'exemple, en France, le secteur des boissons alcoolisées déploie depuis juin 2018 un plan d'action ([accessible ici](#)) visant à lutter contre les comportements et situations de consommation à risque. Plusieurs actions ont ainsi été développées en matière d'information, de formation, de prévention du risque alcool, en particulier à destination des mineurs, des femmes enceintes ou en matière de sécurité routière.

² Voir <https://www.ofdt.fr/BDD/publications/docs/eisxcp2a7.pdf> (juillet 2020)

³ Voir <https://undocs.org/fr/A/RES/73/2> (octobre 2018)

Les Etats membres à l'OMS ainsi que d'autres enceintes internationales ayant confirmé l'approche retenue par la Stratégie Mondiale de 2010, le plan d'action ne devrait pas comporter de propositions qui y sont manifestement contraires ou étrangères.

Ainsi, il est particulièrement étonnant de retrouver dans le plan d'action un appel à un **instrument international juridiquement contraignant** (voir p.4) alors même qu'une telle proposition a été écartée à plusieurs reprises par les membres de l'OMS et que les motivations énoncées reviennent à nier tant les principes de la Stratégie mondiale que la capacité des Etats membres à « *concilier des intérêts différents* » pour reprendre les termes mêmes du texte adopté en 2010.

Ce dernier ajoute que « *les responsables politiques ont pour tâche difficile d'accorder suffisamment d'importance à la promotion et à la protection de la santé tout en tenant compte d'autres visées, obligations – y compris les obligations juridiques internationales – et intérêts. On notera à cet égard que les accords commerciaux internationaux reconnaissent généralement le droit des pays de prendre des mesures pour protéger la santé de leur population, pour autant que celles-ci ne soient pas appliquées d'une façon qui constituerait un moyen d'imposer des discriminations arbitraires ou injustifiables ou des entraves déguisées au commerce. Sous ce rapport, les initiatives prises aux niveaux national, régional et international doivent tenir compte des conséquences de l'usage nocif de l'alcool.* »

Le fait de soumettre les enjeux commerciaux aux impératifs de santé publique constitue d'ailleurs l'un des piliers de la régulation du **commerce international**, depuis 1947 et les [Accords du GATT](#)⁴. Il ne paraît donc pas pertinent que le plan d'action envisage des initiatives particulières dans ce domaine (voir Action WHO7 p.14 et Action WHO3 p.16).

De la même façon, d'autres organisations internationales intègrent d'ores et déjà dans leurs objectifs et travaux la prise en compte d'une consommation responsable d'alcool. Ainsi, l'Organisation de la Vigne et du Vin (OIV), qui regroupe 47 pays, a pour mission de « *participer à la protection de la santé des consommateurs* », notamment en développant des programmes de recherche scientifique sur les spécificités nutritionnelles et sanitaires appropriées pour les produits vitivinicoles et en prenant en compte ces dernières dans l'adoption de normes de production, étiquetage et commercialisation.

Adoptées par les Etats membres de l'OIV, ces recommandations définissent ainsi un cadre international de régulation et d'échanges qui concilie les spécificités de ces produits et les impératifs de santé. Le plan d'action de l'OMS devrait ainsi reconnaître le corpus de l'OIV, plutôt que de chercher à définir de nouveaux standards, notamment en matière d'**étiquetage** (voir Actions MS7 et WHO6 p.14) ; l'étiquetage n'étant en outre pas un sujet compris dans le périmètre de la Stratégie mondiale.

Enfin, le plan d'action appelle à un **mécanisme fiscal international** sur les boissons alcoolisées (voir p.21), alors même que l'OMS ne dispose d'aucune compétence en ce domaine et que les débats en cours, en matière de taxation des services numériques, d'empreinte carbone ou de gaz à effet de serre, montrent la difficulté de construire de tels dispositifs qui soient efficaces, efficients et non-discriminatoires. En ligne avec la Stratégie de 2010, il conviendrait de donner priorité à la mise en place de système fiscaux efficient au plan national et à la lutter contre le commerce illégal d'alcool.

Pour conclure, la FEVS tient à encourager l'OMS à valoriser à leur juste mesure les progrès accomplis, à l'échelle internationale ou nationale, les engagements pris et les résultats obtenus par chaque partie prenante (Etat, scientifiques, ONG, secteur privé...) afin que cela serve d'encouragement à les poursuivre dans la durée et permette à de nouveaux acteurs, qu'ils soient publics ou privés, de s'engager dans cette voie pour réduire collectivement l'usage nocif d'alcool.

⁴ Article XX « Exceptions générales » : « (...) rien dans le présent Accord ne sera interprété comme empêchant l'adoption ou l'application par toute partie contractant de mesures (...) nécessaires à la protection de la santé (...) » ([Accords du GATT de 1947](#))

Fundación Civismo

Country/Location: Spain

URL: <https://civismo.org/>

Submission

Abstract:

Despite targeting ambitious goals, both the plan and the objectives are far from bringing a new mindset for citizens, institutions and economic sectors. The global strategy and last years' regional plans also present a common approach regarding the measures proposed to achieve the objectives, that focus on legal and political changes rather than stressing measures to improve healthcare. However, Fiscal Policy and coercive measures are not the reason why alcohol consumption varies across time, as can be clearly appreciated in Spain. Contrary to that, social tastes, behaviours and even traditions can change in the opposite direction. If the intention is to improve the lives of the citizens potentially affected and not to determine them, the plan should focus on harmful consumption rather than stressing the overall reduction of alcohol.

Attachment(s): 1

00266_46_civismo-web-based-consultation-on-the-who-global-strategy-to-reduce-the-harmful-use-of-alcohol.pdf

Web based consultation on the WHO Global strategy to reduce the harmful use of alcohol

Response:

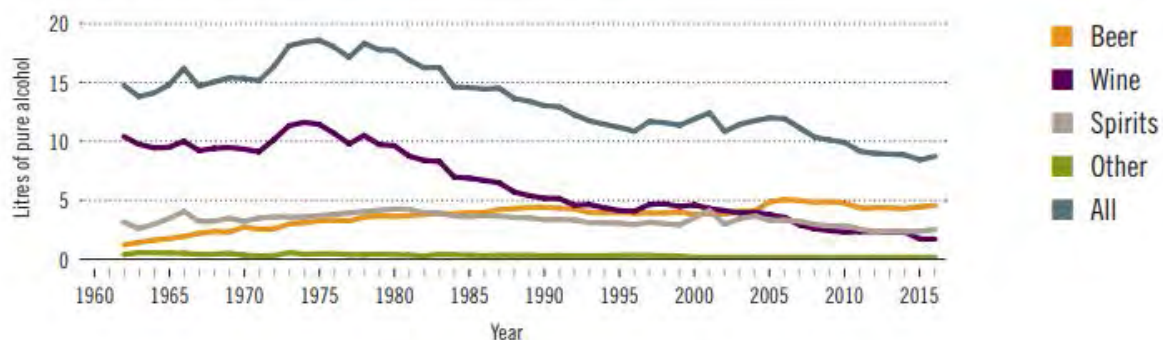
This new Global strategy to reduce the harmful use of alcohol set out five broad objectives, that can be summarized as follows: raised global awareness and commitment by governments, strengthened knowledge base, increased technical support, strengthened partnerships and better coordination among stakeholders, improved systems for monitoring and surveillance, policy development and evaluation purposes.

Despite targeting ambitious goals, both the strategy and the objectives are far from bringing a new mindset for citizens, institutions and economic sectors on which it is expected to have a direct and indirect impact. Contrary, this plan comes after regional strategies implemented in the last decade, some of which are praised in the document itself. Among them, the European action plan to reduce the harmful use of alcohol 2012–2020, a very much similar program with exactly the same goals. Verbatim.

The literature formed by the latest global strategy and last years' regional plans also presents a common approach regarding the measures proposed to achieve the objectives, that may stand for a prohibitionist trend. It emphasises taxation and pricing related norms, as well as recommendations such as a general ban on alcohol advertising. All in all, this set of plans focus on legal and political changes rather than stressing measures to improve healthcare.

Accepting the principles proposed by these strategies, in December 2016, the Government of Spain increased the taxation on the consumption of alcohol and intermediate products by 5%. The policy change was implemented right after a full decade of uninterrupted, constant and sustained decline in recorded alcohol per capita consumption in the country.

Recorded alcohol per capita (15+) consumption, 1961–2016



Source: World Health Organization, 2018

According to data from the World Health Organization (1961-2016), alcohol consumption among Spaniards has registered a practically uninterrupted decline since 1977, in parallel to the drop in wine popularity in Spain (the country with the largest area under vine in the world), due to socio-cultural reasons unrelated to any modification in tastes through incremented tax rates. In fact, wine is the alcoholic beverage with the least tax burden in Spain, precisely because of the economic impact its production has had throughout history on numerous areas and regions across the country.

Therefore, Fiscal Policy and coercive measures are not the reason why alcohol consumption varies across time, as can be clearly appreciated in Spain. Contrary to that, social tastes, behaviours and even traditions can change in the opposite direction. Hence, Fiscal Policy is not the most useful tool for raising global awareness, strengthening knowledge base, increasing technical support or improving monitoring either.

However, the taxation approach is deeply ingrained mindset that goes beyond alcohol or even other substances normally restricted for adults, in the name of health. Thus, the Spanish Ministry of Consumer is drafting norms to raise taxes on sugary drinks and fast food, which it refers to as "junk food". The institution states that childhood obesity affects 23% of the families with the lowest income rates, and only 11% of those with the more resources. Consequently, that statement is a manner of expressing the Government awareness that a tax increase on a product will affect those consumers with fewer resources. That is, it will have a greater capacity to direct the lives of the most disadvantaged people.

At the end of the day, if the intention is to improve the lives of the citizens affected by the measures proposed by the WHO Global strategy to reduce the harmful use of alcohol and not to determine them, the plan should focus on harmful consumption rather than stressing the overall reduction of alcohol through coercion and methods that do not seek to promote alternative and healthier lifestyles but simply to punish certain behaviours.

Accordingly, political measures designed and presented as a solution to reduce the consumption of certain substances, which are promoted at the national and international level, lack methods to reinforce free information, to facilitate the access to alternative options and robust healthcare plans for those affected and potentially affected. They end up being a catalogue of proposals to increase the fiscal effort of citizens.

Antonio O'Mullony
Fundación Civismo
Spain

FUNDACIÓN DE INVESTIGACIONES SOCIALES A.C.

Department/Unit: *DIRECCIÓN DE SERVICIOS A LA COMUNIDAD*

Country/Location: Mexico

URL: www.alcoholinformate.org.mx

Submission

De acuerdo a la solicitud que se hace para esta consulta, ponemos a su consideración algunos comentarios con respecto al enfoque y contenido del documento de trabajo.

La Estrategia Mundial Contra el Uso Nocivo del Alcohol, tiene apertura a una amplia gama de recomendaciones de política pública que permiten adaptarse al contexto de los países; sin embargo encontramos que en este documento se tiene sólo un enfoque SAFER, este hecho tiene el potencial de limitar la capacidad de los países de seleccionar las medidas que tengan un mejor posible impacto en su aplicación. En este sentido, la propuesta de evaluar el progreso sobre el uso nocivo del alcohol sólo con base en la implementación de las recomendaciones de SAFER no parece ser una opción sensible a las distintas problemáticas de los países, pues existen numerosas acciones que se pueden aplicar en favor de la prevención de esta problemática que no necesariamente se encuentran ahí.

Un ejemplo claro de este hecho es lo que ha ocurrido en México en lo relacionado con el uso nocivo del alcohol y la pandemia por COVID-19. Desde la implementación de medidas restrictivas al sector de bebidas con alcohol, se disparó de manera alarmante la cantidad de intoxicaciones por consumo de bebidas adulteradas, que según datos oficiales, asciende hasta el día de hoy a más de 300 muertes en distintos Estados del país. Es importante mencionar que esto ocurre en un país donde alrededor del 36% de las bebidas destiladas se comercializan de manera informal; panorama que sólo tendería a agudizarse si se deciden aplicar restricciones más agresivas. Esto sin tomar en cuenta las problemáticas existentes en lo relacionado con la aplicación de ley. En relación a esto, es importante fortalecer por otras vías la cultura de legalidad, así como la del autocuidado de la salud.

Resalta en el documento, la idea de justificar la aplicación de medidas contempladas en el paquete SAFER tomando como ejemplo lo ocurrido durante la pandemia de COVID-19, sin embargo, algunas encuestas realizadas, como la Encuesta Regional de Uso de Alcohol y COVID-19 en América Latina y el Caribe de la OPS, mostraron reducciones en el consumo excesivo. Este hecho, sumado al (relativamente) poco tiempo transcurrido, hacen que la información al respecto sea incompleta e insuficiente para argumentar sobre acciones de repercusión mundial.

Por otro lado, la colaboración intersectorial ("toda sociedad") tiene mejores resultados en los programas de prevención. La colaboración entre los gobiernos, las empresas y la sociedad civil tiene el potencial de ofrecer beneficios a la población, al sumar esfuerzos y reunir recursos en la persecución de un mismo fin. En México se han obtenido en años anteriores resultados positivos que se estiman en la reducción del 35% de los incidentes de tránsito relacionados con el alcohol de acuerdo con datos del Instituto Nacional de Estadística y Geografía (INEGI); esto se logró por la colaboración de toda la sociedad en la implementación, fortalecimiento y aplicación del programa "Conduce sin alcohol" a nivel nacional.

Llamamos a la OMS a continuar con el enfoque de combatir el uso nocivo del alcohol, como aquel consumo que genera efectos perjudiciales a las personas o a sus entornos. Este énfasis es relevante

dado que posibilita, tanto a los tomadores de decisiones, como a las personas, reconocer en sus iniciativas o en su propia vida, aquellos elementos vinculados con el daño, como el consumo por menores de edad, el exceso, morbilidad, mortabilidad o diversas situaciones de riesgo. Adicionalmente, en México una proporción significativa de quienes incurren en el uso nocivo o en prácticas de riesgo, son usuarios de bebidas informales o que no siguen las mejores prácticas para la protección de grupos vulnerables, por lo que el trabajo con todos los sectores podría incrementar el control.

En relación a la propuesta de etiquetar los ingresos derivados de la aplicación de los impuestos a las bebidas con alcohol para la atención, prevención e investigación de temas relacionados con el uso nocivo, creemos que pudiera tener efectos positivos dado que actualmente sólo una pequeña porción de los mismos se ocupa para fondear acciones al respecto. Este hecho deja pendiente conocer qué beneficios podría tener para la sociedad una adecuada aplicación de los recursos.

Finalmente, consideramos que en México existe una necesidad de encontrar fuentes de financiamiento para diversos proyectos de investigación relacionados con el consumo de bebidas con alcohol. Numerosos investigadores requieren apoyo para impulsar sus ideas y someterlas a los procedimientos necesarios para dotarlos de validez científica. A este respecto, es importante notar que aquellas personas u organizaciones dispuestas a hacerlo son únicamente aquellas interesadas en los resultados, sin que eso signifique de manera automática que existen conflictos de interés. Es por ello que se sugiere a la OMS que desarrolle criterios o lineamientos que posibiliten o aumenten la transparencia de los procesos de investigación, para que el financiamiento no sea un impedimento.

Algo similar ocurre con los programas preventivos que dependen de la financiación del sector empresarial y es necesario privilegiar el apego a las metodologías científicas, antes de que desdeñar esfuerzos por presumir, sin bases reales, un conflicto de interés. Por otro lado, es relevante considerar que los programas de prevención de la sociedad civil tienen mayor continuidad, ya que no hay cambios administrativos tan constantes.

Deseamos que estos comentarios sean de utilidad para dotar al proyecto de un enfoque inclusivo, colaborativo e imparcial, que tenga por finalidad la reducción del uso nocivo del alcohol.

Attachment(s): 1

00203_23_comentarios-fisac-consulta-en-línea-del-documento-para-fortalecer-la-
implementación.vf.pdf

CONSULTA EN LÍNEA SOBRE EL DOCUMENTO DE TRABAJO PARA FORTALECER LA IMPLEMENTACIÓN DE LA ESTRATEGIA MUNDIAL PARA REDUCIR EL USO NOCIVO DEL ALCOHOL

De acuerdo a la solicitud que se hace para esta consulta, ponemos a su consideración algunos comentarios con respecto al enfoque y contenido del documento de trabajo.

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Llamamos a la OMS a continuar con el enfoque de combatir el uso nocivo del alcohol, como aquel consumo que genera efectos perjudiciales a las personas o a sus entornos. Este énfasis es relevante dado que posibilita, tanto a los tomadores de decisiones, como a las personas, reconocer en sus

iniciativas o en su propia vida, aquellos elementos vinculados con el daño, como el consumo por menores de edad, el exceso, morbilidad, mortabilidad o diversas situaciones de riesgo. Adicionalmente, en México una proporción significativa de quienes incurren en el uso nocivo o en prácticas de riesgo, son usuarios de bebidas informales o que no siguen las mejores prácticas para la protección de grupos vulnerables, por lo que el trabajo con todos los sectores podría incrementar el control.

En relación a la propuesta de etiquetar los ingresos derivados de la aplicación de los impuestos a las bebidas con alcohol para la atención, prevención e investigación de temas relacionados con el uso nocivo, creemos que pudiera tener efectos positivos dado que actualmente sólo una pequeña porción de los mismos se ocupa para fondear acciones al respecto. Este hecho deja pendiente conocer qué beneficios podría tener para la sociedad una adecuada aplicación de los recursos.

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Deseamos que estos comentarios sean de utilidad para dotar al proyecto de un enfoque inclusivo, colaborativo e imparcial, que tenga por finalidad la reducción del uso nocivo del alcohol.

Fundacion Saber Beber

Country/Location: Panama

URL: <https://fundacionsaberbeber.org/quienes-somos/>

Submission

Fundación Saber Beber es una organización sin fines de lucro que nace con el propósito de promover y centralizar los esfuerzos de los distintos actores vinculados con el sector de bebidas alcohólicas de Panamá, para sensibilizar y concientizar sobre el consumo responsable y el desarrollo sostenible de la industria, brindando un retorno integral a la sociedad basado en acciones éticas que contribuyan con el bienestar de todos.

Hemos leído el documento de trabajo del plan de acción para fortalecer la implementación de la Estrategia Mundial para reducir el uso nocivo del alcohol, y tenemos los siguientes comentarios:

Comentarios generales:

Fundación Saber Beber ha diseñado su plataforma de iniciativas y acciones tomando como base la Estrategia Global para reducir el uso nocivo del alcohol 2010 de la OMS al considerar dicha estrategia fundamental para el desarrollo y la implementación de sus actividades y a la vez, fomentar una colaboración con el gobierno panameño para trabajar bajo un enfoque de abordaje social más integral para reducir el consumo nocivo del alcohol en Panamá. Por ende, sugerimos ampliamente que el Plan de Acción debe mantener la intención y principios consagrados en la Estrategia Global para reducir el uso nocivo del alcohol 2010.

Fundación Saber Beber aplaude y reconoce la importancia de tener un enfoque de toda la sociedad contenido en Declaración Política de Alto Nivel de las Naciones Unidas de septiembre de 2018; y el Objetivo de Desarrollo Sostenible # 17 de la ONU.

Queremos abundar en la importancia de este enfoque social integral entre el sector público y privado, incluyendo organizaciones no gubernamentales y sociedad civil, para abordar de manera conjunta el uso indebido del alcohol. Asimismo, consideramos fundamental continuar y mantener un diálogo abierto y constructivo entre todos los sectores amplificando los esfuerzos para reducir el uso indebido del alcohol y a la vez, mantener un trato igualitario y equitativo al sector privado frente a otros actores no gubernamentales. Del mismo modo, consideramos importante que el Plan de Acción promueva un catálogo de intervenciones y opciones de políticas como se describen en la Estrategia Global 2010 que facilite a los Estados Miembros la implementación de intervenciones y acciones adaptadas a sus propios contextos nacionales y culturales.

Comentarios específicos:

1. Estamos comprometidos con todas las partes interesadas, incluidas las ONG y el gobierno, en continuar apoyando y realizando acciones en áreas en las que podamos colaborar a largo plazo para reducir el uso nocivo de alcohol.
2. Continuamos apoyando el amplio paquete de opciones de políticas e intervenciones incluidas en la Estrategia mundial como un menú eficaz de opciones para reducir el uso nocivo del alcohol, el cual

permite diseñar e implementar acciones apropiadas para reducir el consumo nocivo del alcohol tomando en cuenta el contexto particular de la República de Panamá.

3. Por el contrario, a través de la promoción exclusiva de la iniciativa SAFER, el documento de trabajo del Plan Acción erosiona el principio básico de contemplar un listado de opciones de políticas adoptado por la Asamblea Mundial de la Salud en 2010. Reiteramos que el plan de acción debe reconocer el amplio paquete de opciones de políticas e intervenciones incluidas en la Estrategia Global 2010 como un catálogo efectivo de opciones para reducir el uso nocivo del alcohol. Creemos que las intervenciones dirigidas a la educación y la prevención suelen ser más eficaces.

4. También continuamos apoyando programas que abordan explícitamente el uso nocivo de alcohol sobre el consumo per se, que penalizan a la inmensa mayoría de las personas que consumen alcohol de manera responsable.

5. Esperamos continuar colaborando con otros actores no gubernamentales/gubernamentales, incluyendo otras instituciones interesadas, para lograr nuestro objetivo común de reducir el consumo nocivo del alcohol bajo un enfoque inclusivo y social. Así como, seguir teniendo un diálogo abierto y transparente con el gobierno, que ha contribuido al éxito de los programas implementados hasta la fecha en Panamá.

Información de soporte adicional sobre esfuerzos de la Fundación Saber Beber

Se adjunta en el formulario un documento PowerPoint con una descripción de las acciones realizadas estos últimos dos años bajo la Fundación Saber Beber.

Attachment(s): 2

00467_04_fsb-balance.pdf

00467_05_panama-fundacion-saber-beber-fsb-12.12.2020.pdf



Fundación Saber Beber es una organización sin fines de lucro que nace con el propósito de promover y centralizar los esfuerzos de los distintos actores vinculados con el sector de bebidas alcohólicas de Panamá, para sensibilizar y concientizar sobre el consumo responsable y el desarrollo sostenible de la industria, brindando un retorno integral a la sociedad basado en acciones éticas que contribuyan con el bienestar de todos.

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2. Continuamos apoyando el amplio paquete de opciones de políticas e intervenciones incluidas en la Estrategia mundial como un menú eficaz de opciones para reducir el uso nocivo del alcohol, el cual permite diseñar e implementar acciones apropiadas para reducir el consumo nocivo del alcohol tomando en cuenta el contexto particular de la República de Panamá.

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Se adjunta en el formulario un documento PowerPoint con una descripción de las acciones realizadas estos últimos dos años bajo la Fundación Saber Beber.

Glasgow Caledonian University

Department/Unit: *Substance use research group*

Country/Location: United Kingdom of Great Britain and Northern Ireland

URL: <https://www.gcu.ac.uk/hls/research/researchgroups/substanceuse/>

Submission

Substance use research group, Glasgow Caledonian University. (Lead: Prof Carol Emslie carol.emslie@gcu.ac.uk) <https://www.gcu.ac.uk/hls/research/researchgroups/substanceuse/>

Twitter: @SubMisuseGCU

Response to WHO consultation on the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol (9 December 2020)

We suggest four key points to strengthen the draft action plan:-

1) The role of economic operators

In some sections of the draft action plan economic operators are given equal standing with other stakeholders, such as civil society and other UN organizations. Glasgow Caledonian University's research strategy is focused around the UN Sustainable Development Goals. Alcohol adversely impacts 13 of these 17 Goals (https://www.euro.who.int/__data/assets/pdf_file/0008/464642/Alcohol-consumption-and-sustainable-development-factsheet-eng.pdf) and the alcohol industry has attempted to undermine the focus on alcohol as an obstacle to sustainable development (<https://movendi.ngo/news/2020/03/11/un-statistical-commission-refines-sdg-alcohol-indicator/>). Therefore, the role of economic operators should be addressed in a separate section of the document, with attention given to their conflict of interest regarding public health.

2) Emphasis on evidence-based policies (WHO best buys / SAFER)

We strongly support an emphasis on each country implementing evidence-based policies to reduce alcohol-related harm (i.e. WHO best buys / SAFER). This is especially important in LMICs which are particularly subject to interference from commercial interests.

3) Restricting digital alcohol marketing and protecting minors

One of the most cost-effective policies to reduce alcohol-related harm is to enforce bans on, or comprehensively restrict, alcohol advertising. The digital marketing of alcohol represents new, high levels of risk, especially for minors. We strongly support statements in this document to regulate digital marketing and social media advertising. This is a global issue, which cannot be solved by any single country, and so it is appropriate that it should be led by WHO.

4) The role of research

The Substance Use research group at Glasgow Caledonian University aims to understand the social context of substance use and develop interventions to reduce harm. We therefore support a broad interpretation of the objective to focus on research which is "highly relevant to the development and implementation of alcohol policies" (p.18). This should include qualitative research which is necessary

to understand the social context of drinking in high risk groups (as attempting to implement interventions without understanding social and cultural drinking practices will be ineffective) (e.g. Emslie et al 2015, Emslie et al. 2017), rapid literature reviews and 'reviews of reviews' on emerging issues (e.g. Fitzgerald et al. 2016), and using innovative methods to understand the lived experience of drinking across the harm continuum (e.g. Lennox et al 2018, Shortt et al. 2017), as well as more conventional epidemiological research.

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About the Substance use research group at Glasgow Caledonian University

Our aim is to understand the social context of substance use and develop interventions to reduce harm. In line with Glasgow Caledonian University's mission to serve the common good, and with UN Sustainable Development Goals, we seek to improve good health & wellbeing, reduce inequalities and contribute to gender equality. Our research aims to improve the health of disadvantaged groups (e.g. heavy drinkers living in deprived areas, older drinkers, people who inject drugs, families affected by substance use) and a major strand of our work focuses on understanding men's and women's relationships with alcohol and addressing gendered stereotypes associated with drinking.

Attachment(s): 0

Global Alcohol Policy Alliance

Country/Location: New Zealand

URL: www.globalgapa.org

Submission

Global Alcohol Policy Alliance (GAPA) appreciate the opportunity to participate in the consultation on the WHO 'Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol'.

There are many very positive aspects to the consultation document and GAPA applauds the work done to prepare the working document. In the attached submission we have pointed to some of these positive aspects that we support. It is however the nature of such a consultation that much of our submission will focus on aspects where we would like to see improvements.

One such general point is that the large number of action points and targets would benefit from reduction in numbers and simplification of language. We would also initially address three points of general concern.

Role of economic operators

In the current document the "economic operators" – i.e., alcohol industry entities (producers, distributors, retailers, etc) – are listed as stakeholders in equal standing alongside civil society and other UN organisations. This is inappropriate, given their inherent conflict of interest and long record of influence undermining effective alcohol policies, including in low- and middle-income countries (LMICs). The alcohol industry should, instead, be addressed in a separate section with due regard to conflict of interest toward safeguarding public health.

Focus on best buys/SAFER

The numerous and sometimes overlapping recommendations in the draft document tend to obscure a focus on the most cost-effective policies to reduce alcohol-related harms. The Action Plan should be strongly framed around every country implementing the five most effective, science-based interventions, as articulated in the SAFER guidance: Strengthening restrictions on alcohol availability; Advancing and enforcing drink driving counter measures; Facilitating access to screening, brief interventions, and treatment; Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship, and promotion; and Raising prices on alcohol through excise taxes and pricing policies. The monitoring indicators should include specific metrics of SAFER implementation, and countries' reporting of the implementation of SAFER policies should be facilitated, especially in LMICs, which currently lack adequate resources and are subject to interference from commercial interests.

More regular reporting on implementation

We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health

Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs and Action Plan in 2030, a progress report and recommendations for the way forward for reducing alcohol harm through alcohol policy should be submitted to the WHO governing bodies by 2028 at the latest to ensure there is no further delay to proportionately addressing any persistent barriers to progress identified through the course of the Action Plan.

In addition, in the attached submission, we make some specific comments, both critical and supportive, and we propose amendments to the text.

Attachment(s): 1

00039_03_gapa-submission-to-who-consultation-11-dec-2020.pdf

Response to WHO ‘Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol’ from Global Alcohol Policy Alliance

11 December 2020

Global Alcohol Policy Alliance (GAPA) appreciate the opportunity to participate in the consultation on the WHO ‘Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol’.

GAPA is a network of non-governmental organisations and people working in public health who advocate for effective alcohol policies, free from commercial interests. GAPA has regional alliances in several regions of the world:

- Asia Pacific (Asia Pacific Alcohol Policy Alliance);
- Africa (East African Alcohol Policy Alliance, Southern Africa Alcohol Policy Alliance, Western African Alcohol Policy Alliance);
- Europe (Eurocare, European Alcohol Policy Alliance);
- Caribbean (Healthy Caribbean Coalition);
- Latin America (Healthy Latin America Coalition)
- United States (U.S. Alcohol Policy Alliance).

Resource centres affiliated to GAPA operate in Africa, European Union, South America, South East Asia, USA and Western Pacific regions.

Introduction

The following are some observations, comments, and suggestions from the Global Alcohol Policy Alliance (GAPA) referring to the consultation question:

“We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration:”

There are many very positive aspects to the consultation document and GAPA applauds the work done to prepare the working document. In the following we have pointed to some of these positive aspects that we support. It is however the nature of such a consultation that much of our submission will focus on aspects where we would like to see improvements.

One such general point is that the large number of action points and targets would benefit from reduction in numbers and simplification of language. We would also initially address three points of general concern.

Role of economic operators

In the current document the “economic operators” – i.e., alcohol industry entities (producers, distributors, retailers, etc) – are listed as stakeholders in equal standing alongside civil society and other UN organisations. This is inappropriate, given their inherent conflict of interest and long record of influence undermining effective alcohol policies, including in low- and middle-income countries (LMICs). The alcohol industry should, instead, be addressed in a separate section with due regard to conflict of interest toward safeguarding public health.

Focus on best buys/SAFER

The numerous and sometimes overlapping recommendations in the draft document tend to obscure a focus on the most cost-effective policies to reduce alcohol-related harms. The Action Plan should be strongly framed around every country implementing the five most effective, science-based interventions, as articulated in the SAFER guidance: Strengthening restrictions on alcohol availability; Advancing and enforcing drink driving counter measures; Facilitating access to screening, brief interventions, and treatment; Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship, and promotion; and Raising prices on alcohol through excise taxes and pricing policies. The monitoring indicators should include specific metrics of SAFER implementation, and countries’ reporting of the implementation of SAFER policies should be facilitated, especially in LMICs, which currently lack adequate resources and are subject to interference from commercial interests.

More regular reporting on implementation

We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs and Action Plan in 2030, a progress report and recommendations for the way forward for reducing alcohol harm through alcohol policy should be submitted to the WHO governing bodies by 2028 at the latest to ensure there is no further delay to proportionately addressing any persistent barriers to progress identified through the course of the Action Plan.

In addition, we make these specific comments. Proposed amendments to the text in the Working Document are underlined:

Setting the Scene

Positive aspects:

- GAPA observes that some key points are made that are important for the elaboration of the global action plan:

1. influence of commercial interests on policy,
2. global inequity due to lack of policy in LMICs,
3. lack of implementation of the Global strategy
4. lack of legally binding regulatory instruments at the international level
5. recognition of the lack of resources
6. strong, updated evidence endorsed by WHA for the “best buys”

To these points, some examples from the Working document with comments and suggestions are listed below:

1. Influence of commercial interests on policy,

eg ‘Strong international leadership is needed to counter interference of commercial interests in alcohol policy development and implementation in order to prioritize the public health agenda for alcohol in the face of a strong global industry and commercial interests.’

Working document page 4

GAPA position: It is important that the action plan recognises that the alcohol industry actors are highly strategic, rhetorically sophisticated and well organized in influencing national policymaking^{1,2} including in LMICs³. The action plan needs to clarify the role of the WHO Secretariat and Member States to address the risk this implies to the implementation of effective evidence-based alcohol policy as covered in our general statement in the beginning of this submission.

2. Global inequity due to lack of policy in LMICs and failure to protect vulnerable citizens

GAPA position: The focus on equity is a very important one particularly as adequate alcohol policy is lacking in LMICs where future increase in consumption and harm can be expected and the failure in HICs to protect the most vulnerable minorities. We propose the following amendments:

‘The disproportionate prevalence of effective alcohol control measures in higher-income countries raises questions about global health equity; it underscores the need for more resources and greater priority to be allocated to support the development, and implementation and evaluation of effective policies and actions in low- and middle-income countries.’

Working document page 2

Further, in this paragraph inequity within countries is broader than based on poverty and inequity between countries is not clear; the adverse effects of alcohol in poorer countries is an important aspect of health inequity.⁴

‘Alcohol use and its impact on health have been increasingly recognized as factors in health inequality. Within a given society, adverse health impacts and social harm from a given level and pattern of drinking are greater for indigenous peoples in

colonised societies, marginalised and poorer individuals. Less economically developed societies also suffer disproportionate harm, and this also produces global inequity. and societies.

Working document page 6

3. Lack of implementation of Global strategy

eg ‘the implementation of the Global Strategy has not resulted in considerable reductions in alcohol-related morbidity and mortality and the ensuing social consequences. Globally, the levels of alcohol consumption and alcohol-attributable harm continue to be unacceptably high’.

Working document page 3

GAPA position: Analysis of WHO Member States self-reports of actions to reduce harmful use of alcohol shows that in the ten years since the WHO Global strategy to reduce the harmful use of alcohol, the implementation has indeed been slow.⁵ This is partly due to the lack of resources allocated to the alcohol work of WHO⁶ and the lack of attention paid to the Global Strategy at national, regional and global level⁷.

4. Lack of legally binding regulatory instruments at the international level

eg ‘Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments.’

Working document page 4

GAPA position: This observation is an important one and GAPA supports the ‘calls for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control.’^{8,9} In the decade since the endorsement of the Global strategy the world has changed in many aspects, including with economic agreements, developments in digital platforms and the adoption of the SDGs. All these warrant international cooperation.

5. Recognition of the lack of resources

eg ‘Limited technical capacity, human resources and funding hinder efforts in developing, implementing, enforcing and monitoring effective alcohol control interventions at all levels.’

Working document page 5

GAPA position: Current funding levels are remarkably small at global, regional, and country levels. In the budget period 2018-2019 only an estimated 1 million USD per year⁶ was allocated for the WHO HQ Head Quarter efforts to develop capacity, instruments, and technical advice for the implementation of the Global strategy to reduce the harmful use of alcohol. There is urgent need for increased resources and expertise at WHO, particularly within the Alcohol and Drugs unit.

6. Strong, updated evidence endorsed by WHA for the “best buys”

eg ‘Evidence on the cost-effectiveness of alcohol policy options and interventions was updated in a revision of Appendix 3 to the NCD global action plan, and this appendix was endorsed by the Health Assembly in Resolution WHA70.11 (2017). [...] “best buys”, include increasing taxes on alcoholic beverages, enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media, and enacting and enforcing restrictions on the physical availability of retailed alcohol.’

Working document page 2

GAPA position: The action plan needs to underline the importance of the best buys and the SAFER measures as pointed out in the general comments in the beginning of this submission.

Negative aspects:

- This section lacks:
 1. information on the corporate strategies of the Transnational Alcohol Corporations (TNACs) including their targeting of LMICs for growth in sales.
 2. projections of increases in consumption and harm
 3. that there is no international regulation of TNACs and the digital platforms which are used to target vulnerable consumers
 4. sensitivity to cultures and populations where alcohol is not an embedded part of the culture

GAPA position: There is a need to cover the above-mentioned aspects in the ‘Setting the Scene’ section.

Re. 1 and 2. TNACs and LMICs and the projections

Data on alcohol exposure indicate that between 1990 and 2017 global adult per-capita consumption increased from 5.9 L to 6.5 L and is projected to continue rising¹⁰ and particularly so in middle income countries in the Americas, Asia and the Pacific¹¹. But these increases are not uniform; as with tobacco, as high-income countries have become saturated and more health oriented, alcohol producers have turned to the markets of countries with growing economies, youthful and urbanising populations, and where the prevalence of drinking commercial alcohol is lower than in high-income countries. These are countries with few of the effective alcohol policies enumerated by the global strategy in place.¹² An evaluation of implementation of NCD policies in 151 countries 2015-2017 shows that alcohol measures were very poorly implemented, and particularly so in Sub Saharan Africa and other LMIC. Over this period implementation increased for several policies, except for those targeting alcohol and physical activity. Alcohol advertising restrictions was the one best buy that was least widely implemented, with decreased uptake in the two-year period¹³.

Re. no. 3 **lack of regulations of TNACs**

Alcohol marketing is essential for the transnational alcohol corporations both in direct recruitment of drinkers and building of brand allegiance but also by normalising alcohol use in new contexts. Alcohol marketing resources are increasingly being shifted to the digital arena, including in the social media platforms which require international cooperation to regulate⁹. The WHO EB decision expressed “deep concern that alcohol marketing, advertising and promotional activity, including through cross-border marketing, targeting youth and adolescents, influences their drinking initiation and intensity of drinking” and requested the Director General to develop a technical report addressing this problem. The action plan needs to clearly reflect this concern and the findings of that report.¹⁴

Re. no. 4. **Sensitivity to cultures where alcohol is not an embedded part of the culture:**

eg ‘The drinking of alcoholic beverages is strongly embedded in the social norms and cultural traditions of many societies.’

Working document page 4

GAPA position: In many cultures and populations non-drinking is the norm. According to the Global status report on alcohol and health¹² more than half the world’s population (57% of population 15+ years) had not consumed alcohol in the previous year. With a Western outlook, that is reflected in the example paragraph above, this fact is often overlooked. For most of those who do not drink alcohol, it is simply not part of their culture to do so. The large segment of non-drinking population is beneficial for global public health, but it is also seen as a great potential for the international alcoholic beverage industry.¹⁵ Cultural traditions of alcohol use are grounded in informal or small scale production of alcohol and these are now replaced by large scale commercial production, distribution and marketing of global alcohol brands, which use all the technologies of modern production and marketing to drive up alcohol consumption, with attendant increased risks for harm. The action plan needs to more strongly reflect the Guiding principle no 7 of the Global strategy: *Children, teenagers and adults who choose not to drink alcoholic beverages have the right to be supported in their nondrinking behaviour and protected from pressures to drink.*

Opportunities for Reducing the Harmful Use of Alcohol

Shortcomings:

- This section does not adequately cover the need for and nature of an international response in line with the Aims of the Global strategy (Box 1)

Ref ‘Aims’ of the Global strategy: to give guidance for actions at all levels; to set priority areas for global action;

Working document page 1

GAPA position: There is a need to focus on the global aspects of the Global strategy. Although this is outlined in the ‘Scope of the Action Plan’ section it should be reflected more strongly in the ‘Operational objectives of the Action Plan’ and in the ‘Key Areas for Global Action’.

PROPOSED OPERATIONAL OBJECTIVES FOR THE ACTION PLAN, GUIDING PRINCIPLES AND KEY AREAS FOR GLOBAL ACTION

Operational objectives of the action plan:

Positive aspects:

- Operational objective 1 focuses on the ‘high impact policy options’
- Operational objective 6 points to the need to increase resources

Shortcomings:

- The need for global action and an international response should be highlighted.
- Objectives 4 and 5 are somewhat overlapping and no. 5 should be adjusted to have a clearer accountability objective.

GAPA position: There is as strong need for monitoring of the most effective policies and for accountability measures to be highlighted in the action plan. While monitoring objectives are described in the introduction to Action area 5, the headline does not sufficiently reflect this and some actions in this action area (for instance Action 1 to Member states) should rather be included under Acton area 4. The monitoring and information gathered as part of the actions outlined need to be reported regularly (ref GAPA’s point in the introduction above) and accountability needs to be clearly addressed and have a strong focus on the effective uptake and implementation of the best buys/SAFER policy measures.

Operational Principles for Global Action

Positive aspects:

- The principles include important principles:
 - ‘equity-based approach’ and
 - ‘protect from commercial interests’.

Negative aspects:

- These important principles are not followed through in actions

GAPA position: Equity-based approach and protection from commercial interest must be given a stronger focus in the design and content of the Action areas

Goals of the Action Plan

The Working document points out:

‘Effective implementation of the action plan at regional levels may require development or elaboration and adaptation of region-specific action plans.’

Working document page 7

GAPA position: The need for regional plans should be reflected more strongly in the Global Action Plan, by replacing ‘may’ with ‘will’ in this section. It could also help identify the regions which will be targeted by commercial interests.

Given the regional differences in current and projected trends in consumption and harm and different levels of policy uptake Effective implementation of the action plan at regional levels ~~may~~ will require development or elaboration and adaptation of region-specific action plans.’

Key Areas for Global Action

GAPA supports the strong focus under Action area 1 of ‘effective and cost-effective policy options’ included in the WHO-led SAFER initiative; the recommendation to implement these cost-effective policies and the related target. The target should include a percentage of LMICs.

Action area 1, Action 1 for MS. Based on the evidence of effectiveness and cost-effectiveness of policy measures, to prioritize sustainable implementation, continued enforcement, monitoring and evaluation of high-impact policy options included in the WHO SAFER technical package.

Working document page 12

GAPA supports the reference to protection from interference from commercial interests as a responsibility of member states:

Action area 1, Action 2 for MS. Ensure that development, implementation and evaluation of alcohol policy measures are based on public health goals and the best available evidence and are protected from interference from commercial interests.

Working document page 12

GAPA does not support: The structure of the action statements includes a role for economic operators as if they are equivalent to other non-state actors; this is not supported. It leads to ‘invitations’ to the economic operators which seem to ignore their commercial responsibilities to shareholders and the reliance for substantial sales on heavy drinking occasions and individuals with alcohol use disorder, for example:

Action area 1, Action 3 for NSA. Economic operators in alcohol production and trade, as well as economic operators in other relevant sectors (such as retail, advertisements, social media and communication), are encouraged to contribute to

the elimination of marketing and sales of alcoholic beverages to minors and targeted commercial activities towards other high-risk groups

Working document page 12

Action area 2, Action 3 for NSA. Economic operators in alcohol production and trade as well as operators in other relevant sectors of the economy are invited to take concrete steps, where relevant [to] refrain from promoting drinking,

Working document page 14

GAPA supports the proposal for member states to increase awareness of the health risks of alcohol use and related overall impact on health and well-being. The option to implement a national alcohol awareness day, however, could be replaced with an alcohol awareness week.

Action Area 2, action 6 for member states: ... including an option of a national alcohol awareness ~~day~~ week to be implemented by public health agencies and organizations and involving countering misinformation and using targeted communication channels, including social media platforms.

Working document page 14

GAPA points out: It is extremely relevant to have mention of trade and investment agreements. Given this was also covered in the Global strategy but has not eventuated to any significant degree it is essential Secretariat resources are allocated for this work.

Action area 2, Action 7 for WHO Secretariat. To facilitate dialogue and information exchange regarding the impact of international aspects of the alcohol market on the alcohol-attributable health burden, advocate for appropriate consideration of these aspects by parties in international trade negotiations and seek international solutions within the WHO's mandate if appropriate actions to protect the health of populations cannot be implemented.

Working document page 14

GAPA points out: At no stage in the action points is there any mention of a role for the WHO Secretariat in monitoring and countering commercial interests' interference with public health policy. This is urgently needed. The responsibility for monitoring and reporting interference from commercial interest is given solely to civil society:

Action area 2, Action 2 for NSA. Civil society organizations, professional associations and academia are invited to monitor activities which undermine effective public health measures

Working document page 14

Action area 3, Action 2 for NSA. Civil society organizations, professional associations and academia are invited to prioritise and strengthen their activities on reducing the harmful use of alcohol, by monitoring and countering undue influences from commercial vested interests that undermine attainment of public health objectives

Working document page 16

GAPA points out: The focus on engagement of stakeholders outlined in the opening paragraph of Action area 3 and the structure of the paragraph confuses the “whole of government approach” and involvement of NSA. This needs clarifications as suggested:

~~New partnerships and the appropriate engagement of all relevant stakeholders are needed to build capacity and support implementation of practical and focused technical packages that can ensure returns on investments within a~~ “Health for All” approach ~~requires.~~ Increased coordination between health and other sectors such as finance, transport, communication and law enforcement. ~~is required~~ for implementation of effective multisectoral measures to reduce the harmful use of alcohol. The new WHO-led SAFER initiative and partnership to promote and support implementation of “best buys”, alongside other recommended alcohol-control measures at the country level, can invigorate action in countries through coordination with WHO’s partners within and outside the United Nations system. Effective alcohol control requires a “whole of government” and “whole of society” approach with clear leadership by the public health sector and appropriate engagement of other governmental sectors, civil society organizations, academic institutions. Consultation with the private sector should not allow commercial interests to influence policy development or weaken implementation of policy and should always be done with consideration of the inherent conflict of interests involved. and, as appropriate, the private sector. There is a need to strengthen the role of civil society in alcohol policy development and implementation.

Working document page 15

GAPA notices the following paragraph:

Action area 3, Action 3 for NSA. Economic operators in alcohol production and trade are invited to focus on their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages, and abstain from interfering with alcohol policy development and evaluation.

Working document page 16

As pointed out in the beginning of this document it is inappropriate to ‘invite’ economic operators to action in a structure where they are listed as stakeholders in equal standing alongside civil society and other UN organisations. The economic operators, the conflict of interests involved, and their possible contributions should be addressed in a separate section of the document which should point out that economic operators shall abstain from engaging in and/or interfering with alcohol policy development and evaluation.

GAPA supports the statement related to Action Area 4 that interventions are based on best evidence. In this context there is a need to point out the problems related to conflicting messaging and competing ‘evidence’ related to research and publications funded and promoted by the alcohol industry, and we propose the following amendment:

There is a need to increase the capacity and capability of countries to create, enforce and sustain the necessary policy and legislative frameworks, develop infrastructure and sustainable mechanisms for their implementation at national and subnational levels, and ensure that implemented strategies and interventions are based on the best available scientific evidence and best practices of their implementation accumulated in different cultural, economic and social contexts. [...]. As part of this capacity to recognise and challenge the conflicting messaging and competing 'evidence' related to research and publications funded and promoted by the alcohol industry is necessary to protect public health policy.

Working document page 17

GAPA supports that the economic operators should not engage in activities competing with public health. In this context the action plan should specify that this includes their involvement in alcohol education and 'responsible drinking' programs. Evidence shows that when they do engage in these kinds of activities, they tend to undermine the information on alcohol harms that they disseminate, and may normalize or encourage alcohol consumption.¹⁶ However, as pointed out in the beginning of this document it is inappropriate to 'invite' economic operators in this manner and this should be addressed in a separate section of the document:

Action area 4, Action 3 for non-State actors: Economic operators [...] and refrain from engagement in capacity-building activities outside their core roles that may compete with the activities of the public health community including involvement in alcohol education and 'responsible drinking' programs.

Working document page 18

GAPA supports the recommendations for monitoring and reporting, including the reconvening of the WHO Expert Committee. However, this should be rewritten to provide a broader mandate in line with the Decision of the EB:¹⁴

Action area 4, Action 7 for WHO Secretariat. Reconvene the WHO Expert Committee on Problems Related to Alcohol Consumption for a comprehensive review of the accumulated evidence on feasible and effective measures to address the harmful use of alcohol, and provide recommendations on the way forward. to strengthen implementation of the Global Strategy.

Working document page 18

GAPA supports the reference to the need to increase resources for accelerating implementation of the Global strategy (best buys/SAFER policy measures). This action needs to be strengthened by requesting this kind of support to be included in official development assistance:

Action area 6, Action 4 for MS. Participate in and support international collaboration to increase resources available for accelerating implementation of the Global

Strategy and action plan to reduce the harmful use of alcohol and support provided to low- and middle-income countries, including in promoting a role of official development assistance in developing and implementing high-impact strategies and interventions.

Working document page 22

GAPA suggestion: The invitation to the economic operators to cease funding research for lobbying purposes lacks clarity and should include all CSR activity. There is a risk that the producers, their social aspect public relations organisations (SAPROs) and Trade Groups will see this as another opportunity to fill the vacuum and sponsor more activities that encourage “responsible drinking.” That is not supportive of public health goals. Also, as pointed out in the beginning of this document it is inappropriate to ‘invite’ economic operators to action in a structure where they are listed as stakeholders in equal standing alongside civil society and other UN organisations. A useful approach will be to recommend to civil society and academia not to enter into formal and informal partnerships with industry and underline that alcohol industry funding should not be accepted.

Action area 6, Action 3 for NSA. Economic operators in alcohol production and trade are invited to allocate resources for implementation of measures that can contribute to reducing the harmful use of alcohol within their core roles, and to refrain from direct funding of public health and policy-related research to prevent any potential bias in agenda-setting emerging from the conflict of interest, and cease sponsorship of scientific research for marketing or lobbying purposes.

Working document page 22

GAPA supports the call for UN and other intergovernmental organisations to mainstream efforts to reduce alcohol problems and the focus on Resource Mobilisation. We applaud the invitation to UN agencies to maintain independence from funding from alcohol producers and distributors. Given that transnational alcohol corporations have and are currently contributing funding to UN agencies through their corporate social responsibility initiatives, there is a need to highlight the conflict of interests involved in industry funding and encouraged independent funding sources.¹⁷

Action area 6, Action 1 for NSA. Major partners within the United Nations system and intergovernmental organizations are invited to mainstream their efforts to reduce the harmful use of alcohol in their developmental and public health strategies and action plans and to promote and support financing policies and interventions to ensure the availability of adequate resources for accelerated implementation of the Global Strategy. It is recommended all UN agencies achieve while maintaining independence from funding from alcohol producers and distributors in recognition of the role such funding plays in facilitating their role as influencers of alcohol policy development.

Working document page 22

GAPA suggests that in the ‘Proposed actions for international partners and non-State actors’ under Action area 6 this should include a request/invitation to philanthropic institutions to provide funding for evidence-based advocacy and capacity building in the alcohol field comparable to that provided for tobacco.

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Government of Japan

Country/Location: Japan

URL: https://www.geneve-mission.emb-japan.go.jp/itprtop_en/index.html

Submission

Japan's comments for the working document

The global strategy should put more focus on making the policy on how to reduce the harmful use of alcohol such as inappropriate drinking habit and inappropriate drinking situation.

Specifically, any statement which aims to eradicate alcohol usage itself, should be avoided.

As stated in WHO reports and the political declaration of the 2018 third UN high-level meeting on the prevention and control of NCDs, any actions regarding the global strategy to reduce the harmful use of alcohol should be conducted with the active participation and cooperation of private sectors. In this light, the economic operators should be invited to the discussion in order to achieve well-balanced and reasonable outcomes.

The working document proposes Member States to increase taxes on alcoholic beverages and introduce such taxes with the aim of securing financial resources for prevention and treatment of alcohol use disorder. However, the tax policy should be determined by each Member State based on their domestic circumstance. It is not appropriate to propose the increase or introduction of taxes on alcoholic beverages without giving the due consideration on the circumstance of each Member States.

green crescent of congo democratic

Department/Unit: *sante*

Country/Location: Democratic Republic of the Congo

URL: no

Submission

que l'O M S appuie les organisation qui travaillent dans la lutte contre les addictions parce que nous ne sommes pas appuyer par notre gouvernement personnellement nous de la R D C

appuyer les jeunes en leur offrant des micro crédits pour leurs petits commerces et ceux qui auront les prêts vont servir de modèles pour les autres

Attachment(s): 0

Green Crescent South Africa

Country/Location: South Africa

Submission

While the Global Strategy has broad-based actions, several suggestions are on offer:

*Implementation of High-Impact Strategies & Interventions

- 1) Strategies should be strong & comprehensive.
- 2) Pricing policies should be well-planned and can document how taxes from the alcohol industry are utilised for prevention & treatment programs.
- 3) Allow for policies to be relevant for the individual context. Low-income, middle-income & high-income countries each require their own set of content. The same would apply for countries with vastly different levels of alcohol consumption.

* Advocacy & Awareness

- 1) The document speaks of awareness and prevention among children and youth. It is suggested that prevention programs may be incorporated into national schooling curricula to ensure effective access to the targeted audience.
- 2) Provision may be made for civil society and academia to not just monitor the activities and interference by the alcohol industry but to also counteract and hold them accountable.

* Partnerships, Dialogue & Co-ordination

- 1) Greater emphasis is needed for the development of regional networks, especially within civil society. In areas of high migration, many challenges are now shared over wider areas. This can also ensure that we are aware of harmful practices in the alcohol industry as they spread across regions.
- 2) A key partner is the media industry.
- 3) Ensure easier access to the WHO resources at localised level.
- 4) A call for greater transparency on the interactions between operators of the alcohol industry and governments, on localised & national level.

*Knowledge Production & Information Systems

- 1) It is critical to have fair representation from low & middle-income countries as well as from nations with low to mid-levels of consumption.
- 2) International collaborations on research are vital for globally effective content.

*General

- 1) Call for greater accountability by the alcohol industry and its partners. This includes those within the media, academia & entertainment industry, among others, who are funded to promote the interests of the alcohol industry.
- 2) Governments & regional to lead by example and ban alcohol at public social functions on all levels.
- 3) Ensure that there is fair representation by the various sectors that make up civil society.
- 4) Engagements via social media should be regularly reviewed due to the highly evolving nature of this medium.

Attachment(s): 0

Hāpai te Hauora

Department/Unit: *Public Health*

Country/Location: New Zealand

URL: <http://hapai.co.nz/>

Submission

We thank the World Health Organization for hearing submissions for the opportunity to provide a submission to convey the voices of the communities we serve in relation to proposed changes to the Sale and Supply of alcohol.

Hāpai Te Hauora are national leaders in Public Health, Policy and Advocacy, Research and Evaluation and Infrastructure services. Hāpai humbles itself in the role of conduit between the community and policy, empowering whanau to be the navigators of their aspirations.

Our key recommendations:

1. Hāpai recommends that equity remain at the forefront of the working document, and that this lens for reducing alcohol harm be explicit throughout the document.

2. Prioritise the three 'Best Buys' in SAFER to achieve the greatest equity gains

3. Preventing and reducing inequities in FASD

4. Alcohol and other drug policy does not have a clear home within government

Prioritising the protection of the child.

5. An international treaty on alcohol control is inevitable and should be prioritised

6. Normalisation of alcohol use

Hāpai advocates for Māori health rights, which are enshrined in Te Tiriti o Waitangi (The Treaty of Waitangi) and affirmed by international tools such as the United Nations Declaration of the Rights of Indigenous Peoples.

Attachment(s): 1



HĀPAI TE HAUORA
— MĀORI PUBLIC HEALTH —

6-8 Pioneer street,
Henderson, Auckland
Aotearoa, NZ

Phone: 09 520 4796
Fax: 09 520 4796
Web: www.hapai.co.nz

Submission to the World Health Organization on the 'Working Document for development of an Action Plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol'

We thank The World Health Organisation for the breadth of consultation to which you have allowed for in paving a way forward in the reduction of the harmful use of alcohol. We acknowledge the candour of the WHO Director-General to ensure that "the report would be elaborated in full consultation and engagement with member states", and look forward to seeing a diversified report back across the global harm reduction sphere.

Hāpai is a Non-Government Organisation, with its core business in Public Health and Indigenous Wellbeing. Hāpai is currently the largest Indigenous Health organisation in New Zealand, with a vision of 'Healthy lives sustained by Healthy environments'. We are national leaders in population health, health promotion and education, policy, advocacy, research & evaluation, and infrastructure services. We support Indigenous communities and whānau (family groupings) to play a role in decision-making on matters affecting their health and well-being.

Hāpai are the largest Māori Public Health organisation in New Zealand, and indeed

Hāpai te Hauora is NOT an organisation deemed to be a non-state actor in relationship with WHO. In maintaining transparency, we declare that:

- a) Hāpai te Hauora is NOT an economic operator in alcohol beverage production, distribution, marketing or sales, nor do we receive funding from such economic operators.
- b) Hāpai te Hauora is not a tobacco company nor are we funded by such companies.
- c) Hāpai te Hauora are not in the business of producing firearms, nor are we funded by such companies.

Please feel free to forward any questions that you have regarding the comments that we have included in this submission. The contact person for this submission, and the person authorised to submit on behalf of the organisation is:

Name: Selah Hart (Chief Executive Officer)
Organization: Hāpai Te Hauora Tapui Limited
Address: Level 1, 6-8 Pioneer Street, Henderson
Country: New Zealand
Phone Number: +6421 083 27944
Email: selah.hart@hapai.co.nz



HĀPAI TE HAUORA
— MĀORI PUBLIC HEALTH —



INTRODUCTION

1. We thank the World Health Organization for hearing submissions for the opportunity to provide a submission to convey the voices of the communities we serve in relation to proposed changes to the Sale and Supply of alcohol.
2. Hāpai Te Hauora are national leaders in Public Health, Policy and Advocacy, Research and Evaluation and Infrastructure services. Hāpai humbles itself in the role of conduit between the community and policy, empowering whanau to be the navigators of their aspirations.
3. Hāpai advocates for Māori health rights, which are enshrined in Te Tiriti o Waitangi (The Treaty of Waitangi) and affirmed by international tools such as the United Nations Declaration of the Rights of Indigenous Peoples.
4. We echo much of the sentiments put forward from other non-state actors here in New Zealand, indicating a unity of thought, and a concerted effort on the part of the Public Health and wider health sector here in New Zealand to address the alarming rates of harm from alcohol within our communities and society at large.
5. Hāpai te Hauora commends the World Health Organization's commitment to proceed with the consultation on the development of an Action Plan (2022-2030) to implement the Global Strategy to Reduce the Harmful Use of Alcohol.
6. Alcohol use remains prevalent in many countries, with global projections forecasting an increased prevalence.¹ In Aotearoa New Zealand, the prevalence of drinking is high, with around 81% of adults (aged 15+ years) reporting past-year use in 2019/20.
7. A notable change over the last decade has been the increase in women's drinking in Aotearoa New Zealand, particularly among population groups that were majority abstainers. For example, whilst more than one-half of Asian women and Pacific women reported abstaining from past-year drinking in 2011/12, more than one half reported past-year drinking in 2019/20.²
8. There has been little change in the overall prevalence of hazardous drinking in Aotearoa New Zealand. In 2019/20, 20.9% of the total population of adults aged 15+ years were classified as hazardous drinkers (AUDIT score ≥ 8).² Hazardous drinking prevalence remains highest among young adults aged 18-24 years old (36.8% males, 27.9% females).²





9. Whilst adolescents have shown positive changes with a lower prevalence of hazardous drinking, significant increases in hazardous drinking have been found among middle-aged to older adults.
10. Māori (Aotearoa New Zealand's indigenous population) experience substantial inequities in hazardous alcohol use. In 2019/20, 43.7% of Māori men were hazardous drinkers, compared to 34.3% of Pacific men and 31.4% among European/other men.² Among women, the differences are even greater, with 29.2% of Māori women reporting hazardous drinking, compared to 16.1% of Pacific women and 14.0% of European/other women.²
11. Among OECD and EU countries, Aotearoa New Zealand has one of the highest rates of youth (15-19 years) suicide.³ There are substantial ethnic inequities in suicide rates in Aotearoa New Zealand, with Māori significantly more likely to die from suicide.⁴ It is clear that alcohol use disorders are a strong risk factor for suicide.⁵
12. In 2019, the third Universal Periodic Review of New Zealand by the Human Rights Council⁶ noted the following: *'New Zealand had unacceptably high levels of family violence. One in three women in New Zealand experienced physical, emotional or sexual violence from a partner in their lifetime'*.
13. Of the recommendations made by the Human Rights Council, many related to addressing violence against women, sexual violence, family and domestic violence and child abuse. Research in Aotearoa New Zealand shows that heavy episodic drinking patterns are associated with more aggression involving alcohol within relationships, and alcohol involvement is associated with increased severity of victimisation.⁷
14. It is clear that strong actions taken on alcohol can assist to reduce the suffering in Aotearoa New Zealand from high rates of suicide and violence. The WHO can, and should, assist Aotearoa New Zealand in this regard.
15. The COVID-19 pandemic has many substantial implications for alcohol use, with impacts likely to be both immediate and long-term.⁸ The longer term impacts are believed to include a normalisation of home drinking, reinforcing or introducing drinking as a way to self-medicate symptoms of stress, anxiety, boredom and an increased prevalence of newly diagnosed patients with alcohol use disorders (as well as relapse among persons with a disorder).⁹⁻¹³
16. Many people will use alcohol to cope with the on-going impacts of the pandemic. Research shows that individuals who drink for coping reasons are at a heightened risk of developing





problems with alcohol.¹⁴ Depression and anxiety have been found to be associated with drinking to cope.¹⁴ Factors such as unemployment, time spent unemployed, redundancy, increased workloads and reduced workplace morale due to loss of staff are also likely to result in a heightened vulnerability to developing new, or exacerbating existing, alcohol-related problems.¹⁵

17. The global health pandemic has the potential to increase alcohol harm inequities. This is already evident in the Aotearoa New Zealand context, with a larger proportion of Māori drinking more heavily post lock-down when compared to pre lock-down (22%), in comparison to other ethnic groups (Pasifika 10%, non-Māori/non-Pasifika 13%).¹⁶
18. Strong, evidence-based actions, free from alcohol industry interference, are required to prevent and reduce inequities during these challenging times.

Recommendations

Hāpai recommends that equity remain at the forefront of the working document, and that this lens for reducing alcohol harm be explicit throughout the document.

19. We believe that the Working Document requires a stronger equity lens, that is embedded and made explicit throughout. All decisions and actions (by Member States and others) must consider and plan for equity from the outset.
20. Māori are significantly more likely to drink hazardously than non-Māori and experience substantially greater life loss from alcohol.¹⁷ Māori are disproportionately harmed from living in close proximity to alcohol outlets¹⁸ and Māori children are five times more likely to be exposed to alcohol marketing than European children in their everyday lives.¹⁹
21. The inadequate partnership with, and protection of, Māori with respect to alcohol-related harm is currently the subject of a claim filed with the Waitangi Tribunal. This claim asserts that by failing to implement effective policies the Government is in breach of Te Tiriti O Waitangi (the Treaty of Waitangi) which was signed by Māori chiefs and the Crown in 1840, and is reinforced through a number of legal tools in NZ.
22. Whilst the Working Document notes the equity gap of implementing effective alcohol policies between low-income and high-income countries, we also wish to signal the substantial inequities in drinking and harm that exist within countries.





23. We urge the WHO to honour its commitment to improving indigenous health, by including actions and indicators that explicitly address equity. For example, the proposed actions for Member States should include the following:
- a. Action Area 2 (Advocacy, awareness and commitment): When Member States produce national reports on alcohol consumption and alcohol-related harm, progress towards equity must be measured and reported.
 - b. Action Area 5 (Knowledge production and information Systems): When Member States collect national data on alcohol use and harm, an equity lens must be built into the data collection process. Equity indicators are of paramount importance. Knowledge production should honour and promote indigenous knowledge systems to gather data on alcohol use and harm. In Aotearoa New Zealand, a lack of equity-specific data and knowledge generation has contributed to entrenched inequities in alcohol harm (especially between Māori and non-Māori). If equity is not measured, then it can't be improved.
 - c. Action Area 6 (Resource mobilisation): Resource distribution must seek to restore power and resources to the people and communities who have been most harmed. In Aotearoa New Zealand, developments are needed that ensure Māori have control over the strategies used, and managing and delivering their own services whilst working in partnership with the State. Earmarking funding from alcohol taxes should be utilised to restore power and resources.
 - d. Action Area 3 (Partnership, dialogue and co-ordination): Indigenous populations must be visible in the plan and specifically described as mutual partners with the State, and not rendered invisible by being subsumed into a list of stakeholders to engage in relevant processes.
24. An equity assessment should consider the impact of interventions and policies to reduce alcohol-related inequities, the gaps in knowledge to be addressed, the needs and values of groups experiencing inequities, the plan for partnership with groups disproportionately harmed as well as monitoring and evaluation by equity.
25. An equity and human rights approach must also explicitly recognise and address the relationship between racial discrimination and alcohol use. In the report of the third Universal Periodic Review of New Zealand by the Human Rights Council⁶, the following was noted: *“The impacts of colonization continued to be felt, through entrenched structural racism and poorer outcomes for Māori”*.
26. Research in Aotearoa New Zealand found that adolescent students who had experienced ethnic discrimination were more likely to report an episode of binge drinking in the past four weeks.²⁰





27. Among Māori adults, experiencing discrimination was found to be significantly associated with elevated levels of hazardous alcohol use.²¹ Mediation analysis revealed that 35% of the effect of Māori ethnicity on hazardous drinking could be acting through experience of discrimination.
28. It is clear that racism is a social determinant of health inequities. The WHO needs to play a key role in transforming institutional racism. The Working Document must recognise the role of racism and include strong efforts by Member States to address it.

Prioritise the three 'Best Buys' in SAFER to achieve the greatest equity gains

26. We recommend that the Working Document needs to highlight more clearly, and focus on, the most cost-effective policies to reduce alcohol-related harms (and their inequities), especially in the section on 'Key areas for global action'.
27. In particular, high-impact actions need to be developed and prioritised by Member States that:
- Increase the price of alcohol
 - Reduce availability of alcohol; and
 - Restrict the marketing of alcohol.
26. The above strategies offer the greatest potential to prevent and reduce inequities in alcohol-related harms. The implementation of these requires monitoring and reporting.
27. We further recommend that the Action Plan be strongly framed around every country implementing the five most effective, science-based interventions, as articulated in the SAFER guidance.
28. The monitoring indicators should include specific metrics of SAFER implementation, and countries' reporting on the implementation of SAFER policies should be supported, especially in Low and Middle Income Countries (LMIC), which currently lack adequate resources and are often subject to interference from commercial interests.

Preventing and reducing inequities in FASD

29. We believe that Fetal Alcohol Spectrum Disorder (FASD), as a leading cause of preventable disability, should be explicitly recognised within the Working Document. The negative impacts on the brain and body of individuals prenatally exposed to alcohol lead many individuals with FASD to experience significant challenges in their daily life. Many will need support with motor skills, physical health, learning, memory, attention, emotional regulation, and social skills.
30. Research studies have shown that:
- between 10-20% of people in prisons and other correctional settings have an FASD.²²
 - around 80% of adults with an FASD will not be able to live independently without some level of support.²³





- children and adolescents with an FASD have a 95% lifetime likelihood to experience mental health issues.²⁴
- people with FASD have a higher risk (up to five times greater) of suicidal behaviour than the general population.^{23,25,26}
- life expectancy of people diagnosed with Fetal Alcohol Syndrome under the International Classification of Disease (ICD) have a shockingly low life expectancy of 34 years on average. The leading cause of death were external causes, with 15% of these being death by suicide.²⁶

31. FASD remains a "hidden disability" and must be given greater attention in our global efforts to reduce inequities in alcohol-related harm. Preventing FASD and reducing its associated secondary harms is imperative and efforts must be visible within the Working Document.

32. National alcohol policies must include evidence-based actions to prevent FASD and its secondary harms. This includes research on prevalence, provision of early diagnosis, delivery of FASD-informed care across sectors, and on-going and sufficient support for individuals and families living with FASD.

We recommend that Action Area 2 (Action 2 for Member States) be expanded to include:

- National alcohol policies should include evidence-based actions to prevent FASD and its secondary harms.
- Diagnosis before the age of six years is identified as a protective factor associated with a lower likelihood of experiencing secondary harms from FASD.²⁷ However, in Aotearoa New Zealand diagnostic services for FASD are rarely accessible and often very costly.

33. Failure to provide for early identification denies the individual and wider family the knowledge on which to build strength-based early intervention, thereby furthering inequities. Much of the harms from FASD could be ameliorated by appropriate early intervention that is guided by the individual diagnosis.

34. We therefore recommend that Action Area 4 (Technical support and capacity building) for Member States should expand beyond actions for health professionals to identify and manage hazardous drinking and disorders, to include:

- a. Develop and strengthen the capacity of multi-disciplinary health services teams to diagnose Fetal Alcohol Spectrum Disorder.

35. Furthermore, adequate training is required across the health, education, care and protection, and justice systems to enable safe and appropriate treatment of individuals with FASD. Without this training and resulting understanding of what works best, FASD harms continue to occur as individuals are misdiagnosed, misunderstood and mistreated.

36. We therefore recommend that Action Area 4 (Technical support and capacity) for Member States includes the following:





Develop and strengthen the capacity across sectors to deliver FASD-informed care.

37. Support is also required for individuals and families living with FASD. Children and young people who receive a diagnosis must have a clear pathway for support under an umbrella of disability services. We therefore recommend that Action Area 6 (Resource mobilisation) requires that Member States:

Increase allocation of sufficient resources to support individuals and families living with FASD.

38. Finally, we commend the WHO for initiating the International Collaborative Research Project on Child Development and Prenatal Risk Factors with a focus on FASD to help gain a better understanding of its prevalence, severity and impact. In Aotearoa New Zealand, there has been no population-based prevalence study of FASD. We recommend that Action Area 5 (Knowledge production and information Systems) include the following:

39. *Actions for the WHO Secretariat:* Further develop the International Collaborative Research Project on Child Development and Prenatal Risk Factors (with a focus on FASD), and promote and support Member States to conduct a FASD population-based prevalence study.
40. *Actions for Member States:* Support the implementation of the WHO-initiated population-based FASD prevalence study.

Requirement for Member States to have a designated 'home' for alcohol control

41. We commend the WHO for proposing that Member States increase allocation of resources to reduce harmful alcohol use. However, we believe that stronger actions need to be proposed that require Member States to have a dedicated 'home' for alcohol control in government services.
42. The New Zealand Government Inquiry into Mental Health and Addiction noted the following with regards to leadership on alcohol control in Aotearoa New Zealand²⁸:

Alcohol and other drug policy does not have a clear home within government

43. Central Government appears to have lost traction on alcohol and other drug issues, although we note the recent formation of a cross-party group on drug harm reduction. Overall, leadership is weak and it is unclear where responsibility for coordinated strategy and policy lie. Given the significant role that alcohol and other drugs play in people's wellbeing across New Zealand, a unit with a strong cross-sectoral focus dedicated to advancing alcohol and other drug policy is critical.
44. Given the magnitude of harm and inequities, commitment to leadership and stewardship on alcohol control is essential. This is recommended in the Global Alcohol Strategy to reduce Harmful Alcohol Use.²⁹





Prioritising the protection of the child

45. Of particular concern has been the international dissemination of ‘Smashed’ and other industry-funded school-based education programmes. As an example, ‘Smashed’ commenced in the United Kingdom in 2005 and to date has engaged more than half a million students internationally.³⁶
46. These programmes are directed at very young students; an age group that has heightened vulnerability to alcohol-related harm. The teaching resources of the ‘Smashed’ ‘responsible drinking’ programme have been critiqued and published in a peer-reviewed journal³⁶, with an accompanying editorial.³⁷ The involvement of schools in alcohol industry-funded education has the potential to do more harm than good, especially if it replaces the teaching of evidence-based harm reduction materials in the class and has the effect of delaying the implementation of strong alcohol policies.
47. We believe the following statement in the Working Document needs to be addressed by Member States:
48. “Economic operators.....are invited to...refrain from engagement in capacity-building activities outside of their core roles that may compete with the activities of the public health community.”
49. We are in agreement with Ireland’s Health Minister³⁸ and Education Minister³⁹ on the need to separate out the alcohol industry from being part of the conversation, with the former stating that “it’s completely and utterly bizarre that you’d have a body funded by the drinks industry educating our kids about the dangers of alcohol... I mean it’s ridiculous” (para. 3).³⁸
50. The commercial determinants of health have also been raised as a children’s right issue. Earlier this year, the WHO-UNICEF-Lancet Commission called for the development of a new protocol to regulate against commercial harm to children.⁴⁰ The protocol is an optional instrument to the UN Convention on the Rights of the Child.
51. The rationale for developing such a protocol is the recognition of the growing threat of the commercial sector to child health and wellbeing. This includes the ubiquitous presence of alcohol advertising (including digital communications) and exposure to industry-funded education in their schools, both serving to undermine their health and wellbeing.
52. We therefore recommend that the Working Document include the following under Area Action 2 (Advocacy, awareness and commitment) for Member States:
53. Commit to advocating to schools to implement evidence-based alcohol harm reduction education resources and undertake activities to review programmes associated with the alcohol industry.

An international treaty on alcohol control is inevitable and should be prioritised

54. As described in the Working Document, alcohol remains the only psychoactive substance that lacks legally-binding regulatory instruments at the international level.⁴²





55. The current process of developing an Action Plan provides an important and timely opportunity, especially for fostering deliberation of a more effective instrument as well as strengthening the global governance of alcohol.⁴³
56. We believe that a stronger global plan and a legally binding framework, akin to the Framework Convention on Tobacco Control (FCTC), are urgently needed to support individual Member States to withstand the industry's opposition to regulation, and to prioritise action on alcohol, as has been advocated previously.
57. Most importantly, the WHO and Member States need to demonstrate strong leadership in advancing the global governance of alcohol control.
58. It is imperative to have a codified international instrument to help Member States, especially low-income countries, to protect population health. There is a growing inadequacy for domestic law and regulations to attain public health objectives at the country level.
59. This is especially in relation to the proliferation of digital advertising, particularly on social media platforms. Collaboration between countries and social media enterprises is necessary to address emerging marketing tactics employed by multi-national firms on digital platforms. A legal framework for alcohol control is an important step towards reducing harm from digital marketing.
60. Also of relevance is Action 6 (in Action Area 2) proposing that Member States ensure appropriate consumer protection measures through development and implementation of labelling requirements for alcoholic beverages. As witnessed in Canada, legal threats are mounted in relation to labelling, particularly for cancer warning labels.⁴⁴
61. Without a legal health treaty, legal challenges and litigation continue to impose a chilling effect on governments to implement effective alcohol policies and interventions. It took more than 20 years of strong advocacy in Australia and Aotearoa New Zealand to ensure an evidence-based alcohol pregnancy warning label is placed on alcohol products.⁴⁵ It is incredible to comprehend the suffering by individuals and families across Aotearoa New Zealand and Australia that could have been prevented from earlier implementation of a warning label.
62. It is clear that trade and economic agreements have become a legal tool manipulated by the alcohol industry to undermine public health measures. Below are some examples:
63. The Alcohol Minimum Pricing Bill (passed by the Scottish Parliament in 2012) was challenged by the alcohol industry under EU single market law. The industry challenged the compatibility of the proposed bill at the time with the EU law. This included a claim that the Scottish legislation could constitute a quantitative restriction on trade and distort competition among alcohol distributors.⁴⁶
64. Alcohol marketing and advertising restrictions introduced in France, known as 'The Loi Evin', were challenged by the alcohol industry stakeholders in the European Court.⁴⁷
65. We believe that lessons can be drawn from the Framework Convention on Tobacco Control. The negotiation process of the WHO FCTC facilitated multilateral collaboration on aspects of tobacco





- control that transcended national boundaries. It also promoted national action and international co-operation.⁴⁸
66. Since the WHO FCTC came into force in 2005 (after the 40th member state had ratified the treaty), the Conference of the Parties has become a venue for Member States to collaborate, deliberate on tobacco control policies, and develop new guidelines and protocols (e.g. Guidelines on Article 5.3, Protocol on illicit tobacco trade). The WHO FCTC has also advanced the development of domestic law.⁴⁹ It has provided a legal framework for implementation and given government's the authority to act.⁵⁰
 67. Lastly, the WHO FCTC has provided legal weight to Member States in times of legal challenges launched by the tobacco industry.
 68. In a study of the 96 court decisions concerning legal challenges to tobacco control measures⁵⁰, the WHO FCTC was cited in 45 decisions. Decisions both citing and not citing the WHO FCTC were largely decided in favour of governments, with 80% of WHO-FCTC-citing and 67% of non-WHO-FCTC citing cases upholding the measure in its entirety and on every ground of challenge.
 69. As the authors note in the study, it was difficult to 'prove' that the WHO FCTC was directly responsible for the positive outcome of any particular case, despite the higher number of citations in cases that were upheld. Many cases were decided on multiple grounds, each of which alone could be sufficient to dismiss a challenge. A lack of counterfactual, for what would have happened if there was no WHO FCTC, limits determination of causality.⁵⁰
 70. However, the WHO FCTC and its guidelines have helped to translate a large and complex body of scientific evidence into a format that is understandable to legal institutions and assimilable to legal concepts. The WHO FCTC has also demonstrated international consensus in support of public health measures and assisted to establish whether or not a measure is reasonable, proportionate or justifiable.⁵⁰
 71. We believe that an Framework Convention on Alcohol Control is inevitable. This generation should be leaving a legacy for the next by protecting its rights to be free from alcohol harm and interference from the alcohol industry.
 72. Whilst the Framework is in development, we recommend the Working Document put in place a set of guidelines similar to Article 5.3 of the WHO FCTC. See paragraph 66.
 73. Further, we support GAPA's position on strengthening the provisions of the WHO Framework for Engagement with Non-State Actors (FENSA), by including specific reference to alcohol as well as improving the implementation of FENSA.





HĀPAI TE HAUORA
MĀORI PUBLIC HEALTH

6-8 Pioneer street,
Henderson, Auckland
Aotearoa, NZ

Phone: 09 520 4796
Fax: 09 520 4796
Web: www.hapai.co.nz

Normalisation of alcohol use

74. We support the submission of the Health Coalition Aotearoa that recommends the Working Document recognise the many cultures (whether based on ethnicity, religion, age or peer group) who have not normalised use of alcohol. In cultures and societies where alcohol is used, this has often traditionally been small scale home production that is now being replaced by commercial alcohol and aggressive marketing by transnational corporations, leading to increased consumption and harm. Especially in LMICs, this is placing huge burdens on governments and NGOs, through social and health services and systems.

CONCLUSION:

75. Strong actions taken to reduce alcohol use and harm can significantly improve the wellbeing of every person in Aotearoa New Zealand, for this generation and the next. In particular, our most vulnerable (children, women, disadvantaged populations) will benefit the most from leadership taken on alcohol.

76. The entrenched inequities in alcohol harm in Aotearoa New Zealand must be prioritised and addressed. In particular, New Zealand must uphold its obligations to Te Tiriti o Waitangi to protect Māori health.

77. By strengthening the Working Document, the WHO can greatly support Aotearoa New Zealand to reduce its shamefully high youth suicide and family violence rates. The possibilities for Aotearoa New Zealand to reach its potential are endless. We all have a duty to act.

78. We once again thank you for the opportunity to provide feedback to this consultation, and look forward to the report to the report to the 73rd World Health Assembly, detailing “the implementation of WHO’s global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward”.

Kind Regards,

Selah Hart
Chief Executive Officer
Hāpai Te Hauora Tapui Limited

DATED 13 DECEMBER 2019



HĀPAI TE HAUORA
MĀORI PUBLIC HEALTH

Health Canada

Department/Unit: *Office of Alcohol Policy*

Country/Location: Canada

URL: <https://www.hc-sc.gc.ca/>

Submission

You will find enclosed comments from the Government of Canada and some provinces on the working document for the development of the action plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol.

Attachment(s): 1

00401_50_201212-canada-submission-who-consultation-working-document.pdf

**Canada's response to WHO consultation for the development
of an action plan (2022-2030) to implement the
Global strategy to reduce the harmful use of alcohol**

National comments:

- The Government of Canada acknowledges the negative impacts that alcohol can have on communities and individuals, which is why it is committed to addressing alcohol-related harms more broadly through a public health approach. The Government of Canada reintroduced alcohol as a part of its drug strategy - the Canadian Drugs and Substances Strategy. During an extensive consultation of the strategy in 2018, experts and stakeholders made several recommendations to address the harms and risks associated with alcohol use, many of which are included in the working document such as controlling the affordability and availability of alcoholic products. The future action plan for implementing the Global Strategy will provide additional input to inform Canada's future policies to address the health and social harms of alcohol use among its population.
- More specifically, the Government of Canada shares the concerns raised in the working document about the health and economic impacts of alcohol use. Alcohol was responsible for more than 18,000 deaths and close to \$17 billion in health and social costs in Canada in 2017. Alcohol surpasses all other substances, even tobacco, in terms of costs to Canadian society. It is expected that these numbers will remain high for the foreseeable future since per capita alcohol consumption in Canada has not significantly changed for the past 10 years, which mirrors the trend in per capita alcohol consumption worldwide.
- The Government of Canada agrees with the working document about the challenges of implementing effective policies to control alcohol. Alcohol use is well entrenched in Canadian culture. The Government of Canada admits that more could be done to better inform the population about the health and social harms it causes. There are also competing health crises such as addressing the current COVID-19 epidemic and the opioid overdose crisis. The role played by alcohol in the Canadian economy is also a significant consideration.
- The Government of Canada supports the aim of the action plan, which consists of giving "guidance for action at all levels and to set priority areas for global action". Such guidance and priority setting will be helpful for Parties to make more informed decisions for choosing and implementing alcohol policies while still respecting each jurisdiction's capacity for taking action over the next ten years. However, as mentioned in the working document, progress was very slow in implementing the Global Strategy to Reduce the Harmful Use of Alcohol over the past ten years. Many Parties have raised concerns about the voluntary approach proposed to implement it. It is hoped that the action plan will provide an added incentive to Parties to increase

the pace for introducing effective alcohol policies over the next ten years and reach the global targets for each action area.

- The Government of Canada shares WHO's concern about the COVID-19 epidemic and its impact on alcohol consumption. Canadian surveys show an increase in alcohol consumption among a significant proportion of the population since the beginning of the pandemic. The action plan needs to highlight the importance of implementing effective alcohol policies during public health crisis which can prevent the unexpected consequence of increasing alcohol consumption.
- The Government of Canada recognizes that the comprehensive approach used for the action plan and the recommendations it includes are evidence-based policies to address alcohol-related harms. Research shows that a multi-pronged strategy provides a comprehensive, effective and cost-effective response to harmful alcohol consumption. As an example, the comprehensive approach used in Canada to control tobacco use yielded great results in terms of reducing smoking and related harms. For the action plan, the six action areas with their extensive lists of proposed recommendations for Member States, the WHO Secretariat, international partners and non-State actors hold promise for addressing the global public health impact of alcohol.
- The Government of Canada acknowledges that it has limited reach when it comes to international issues such as the expanding use of social media to target more effectively potential consumers with advertising campaigns or any potential rise in illegal transnational trade. Such issues can only be addressed through international cooperation and should represent a key focus of international instruments such as the action plan and the Global Strategy.
- The Government of Canada questions many of the actions proposed for economic operators such as inviting them to abstain from interfering with alcohol policy development and evaluation or to disclose data on production and sales of alcoholic beverages and data on consumer knowledge, attitudes and preferences regarding alcoholic beverages. For example, obtaining such data from Canadian tobacco manufacturers was only possible by adopting the Tobacco Reporting Regulations. The action plan should focus instead on inviting economic operators to implement "measures that can contribute to reducing the harmful use of alcohol within their core roles."

Subnational comments:

- In Canada, subnational work is critical to the implementation of these strategies, given where the regulatory authorities lie. To that end, it would be helpful to speak to subnational governments more directly within the document.
- The working document should also suggest, as part of public health protocols and accountability structures, a recommended action to develop commitment and

accountability mechanisms for public health to ensure that public health systems are continuing to prioritize strategies to reduce the harmful use of alcohol.

- Because the document is a global document and written for all countries regardless of where their alcohol policies are at, it is at times too general and could include more detailed recommendations for action. As the document is currently written, countries that have some alcohol policies in place could “check the box” of the recommended action when there is likely substantially more that could and should be done in terms of implementation. Ideally, there would be actions that continue to push countries even if they have some relatively advanced alcohol policies and actions. For example, the proposed actions for Member States in Action Area 1, Action 1 could be amended to include “the development of national and subnational policies and legislative measures that address *all* key areas of the WHO SAFER technical package.”
- The recommended actions or “best buys”, and the clear direction found in the SAFER initiative are welcomed. This direction and knowledge base helps to provide sound credible evidence to support and advance the policy work in provinces and territories.
- The impacts of the harmful use of alcohol, including health, social and economic costs, aligns with the Canadian Alcohol Policy Evaluation project and the Substance Use Costs and Harms Study.
- The acknowledgement of the social and cultural role of alcohol is important; as is the recognition of the paradox for governments to balance public health needs with economic development interests.
- The inclusion in the working document of the impact of COVID-19 on alcohol consumption is appreciated.
- While the intent of a “World No Alcohol Day” is understood, for people with alcohol use disorder, a managed alcohol program could be the best option for them in their journey in recovery and a day without alcohol could lead to significant withdrawal. There may be some unintended stigma for people with living experience.
- Prominent alcohol warning labels and marketing and advertising controls are important alcohol policies. Prominent warning labels are a federal requirement for other legal controlled substances such as cannabis and tobacco.
- It may not be relevant for the global strategy, but the impact of trauma as a causal factor in people developing alcohol use disorder is significant. This has implications for prevention and treatment work.

Health Coalition Aotearoa

Department/Unit: *HCA Board*

Country/Location: New Zealand

URL: <https://www.healthcoalition.org.nz/>

Submission

Health Coalition Aotearoa Inc. submission to:

WHO web-based consultation on the Working Document for Development of an Action Plan to strengthen implementation of the Global Strategy to Reduce Harmful Use of Alcohol

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2. Aligned to our mission, the Coalition has set the following goals:

- Improvements in the societal determinants of health;
- Control over the commercial determinants of health;
- Strengthened public health infrastructure and funding for prevention;
- Reduced harm and inequities from alcohol use;
- Smokefree Aotearoa with reduced inequities by 2025;
- Reduced harm and inequities from unhealthy foods and beverages; and
- Reduced obesity prevalence and inequities in children and adults.

Health Coalition Aotearoa's Comments on the Working Paper

3. The Coalition has read the working document for development of an action plan to strengthen implementation of the Global Strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration.

Overarching comments

4. The Coalition congratulates the WHO for recognising the need for more effective action and implementation of the Global Strategy to Reduce Harmful Use of Alcohol. In Aotearoa (New Zealand), nearly half of all alcohol is consumed in heavy drinking occasions and one in four drinkers consumes alcohol at hazardous levels. The immense influence of the global alcohol industry means that even a high-income country like New Zealand, with strong democratic processes and relatively little corruption, cannot achieve the level of alcohol regulation that it seeks. For example, supermarket companies across

New Zealand mount legal challenges to prevent any reduction in alcohol outlet density and/or retail hours sought by local councils and communities through due process.

5. The prevalence of (and inequities in) alcohol consumption and harm in New Zealand warrants strong, evidence-based alcohol policies. Harm from alcohol affects many non-drinkers as well as drinkers themselves, including those born with FASD, and many children.

a) Equity demands stronger focus and action

6. The Coalition believes that the working document requires a stronger equity lens, that is embedded and made explicit throughout. All decisions and actions (by Member States and others) must consider and plan for equity from the outset.

7. In Aotearoa, alcohol use is responsible for substantial health, social and economic inequities between population groups and has broad inequitable consequences, for example in the employment sector and criminal justice system. Harms from alcohol affect Māori (indigenous) people more than non-Māori, as in other similar colonised countries. Māori children are five times more likely to be exposed to alcohol marketing than European children in their everyday lives.

8. The inadequate partnership with, and protection of, Māori with respect to alcohol-related harm is currently the subject of a claim filed with the Waitangi Tribunal*. This claim asserts that by failing to implement effective alcohol policies the Government is in breach of Te Tiriti O Waitangi (the Treaty of Waitangi) which was signed by Māori tribes and the Crown in 1840.

9. The Coalition urges the WHO to honour its commitment to improving indigenous health, by including actions and indicators that explicitly address equity. For example, the proposed actions for Member States should include the following:

- Action Area 2 (advocacy, awareness and commitment): When Member States produce national reports on alcohol consumption and alcohol-related harm, progress towards equity must be measured and reported.
- Action Area 5 (Knowledge production and information systems): When Member States collect national data on alcohol use and harm, an equity lens must be built into the data collection process. Knowledge production should honour and promote indigenous knowledge systems to gather data on alcohol use and harm. In Aotearoa, a lack of equity-specific data and knowledge generation has contributed to entrenched inequities in alcohol harm (especially between Maori and non-Maori). If equity is not measured, then it can't be improved.
- Action Area 6 (resource mobilisation): Resource distribution must seek to restore power and resources to the people and communities who have been most harmed. In Aotearoa, developments are needed to ensure Māori have control over the strategies used, and are managing and delivering their own services whilst working in partnership with the State. Earmarked funding from alcohol taxes should be used to restore such power and resources.
- Action Area 3 (Partnership, Dialogue and Co-ordination): Indigenous populations must be visible in the plan, specifically described as mutual partners with the State. They must not be rendered invisible by being subsumed into a list of stakeholders to engage in relevant processes.

b) Prioritise the three 'Best Buys' in SAFER to achieve the greatest equity gains

10. The Health Coalition Aotearoa recommends that the working document needs to more clearly highlight, and focus on, the most cost-effective policies to reduce alcohol-related harms (and their associated inequities), especially in the section on 'key areas for global action'.

11. In particular, high-impact actions need to be developed and prioritised by Member States that:

- Increase the price of alcohol
- Reduce availability of alcohol; and
- Restrict the marketing of alcohol.

12. The above strategies offer the greatest potential to prevent and reduce inequities in alcohol-related harm.

13. We further recommend that the Action Plan should be strongly framed around every country implementing the five most effective, science-based interventions, as articulated in the SAFER guidance.

14. The monitoring indicators should include specific metrics of SAFER implementation, and countries' reporting on the implementation of SAFER policies should be supported, especially in low- and middle-income countries (LMICs), which currently lack adequate resources and are often subject to interference from commercial interests.

c) Role of economic actors

15. We are very concerned that the working document lists commercial alcohol industry entities (referred to as 'economic actors'), as stakeholders with equal standing alongside civil society and other UN organisations. This is inappropriate, given their explicit conflict of interest and long record of opposing effective alcohol policies, not only in Aotearoa New Zealand but right across our Western Pacific region and beyond.

16. The Coalition does not support the alcohol industry being included as an 'equal' with non-commercial interests. Industry should be addressed in a separate section with due regard to their conflict of interest with respect to public health. For example, the structure of the action statements includes a role for economic operators as if they are equivalent to other non-state actors. Health Coalition Aotearoa does not support this.

17. In 2018, the report of the New Zealand Government Inquiry into Mental Health and Addiction noted the role of commercial actors and stated the following :

Despite alcohol's harm, New Zealand has a normalised heavy drinking culture that, by and large, does not recognise current alcohol use as a crisis. Strong vested interest groups have incentives to resist change. We see parallels with tobacco control and smoking, and believe a similar approach will be needed to tackle the harmful use of alcohol.

18. In 2018-2020, the New Zealand Government commissioned an independent review into the health system to determine recommendations for system-level changes that would be sustainable, lead to better and more equitable outcomes for all New Zealanders and shift the balance from treatment of

illness towards health and wellbeing. The final report noted the following with regards to the commercial drivers of ill health:

Faced with growing challenges from NCDs, the Review is clear that there is a need for much more concerted action at national, regional and local levels to address the commercial determinants of health.

19. The Health Coalition Aotearoa strongly believes that international plans and strategies can provide countries, such as Aotearoa, the explicit provision and mandate to address the commercial determinants of health.

20. The Coalition does not support action statements being framed as invitations to commercial operators to act against their own commercial interests by voluntarily adopting effective strategies to reduce consumption and harm; for example, to eliminate marketing and promotion of drinking. This does not represent evidence-based intervention. Equally, we are also concerned that civil society actors are “invited” to provide all proposed monitoring and countering of industry influence, which we see as part of any global action.

21. Role of commercial actors in funding research: The Coalition notes the working document’s reference to economic operators ceasing funding research for lobbying purposes. We strongly believe that this needs to be stronger and clearer or it will be seen as an opportunity instead to increase sponsorship of activities that encourage ineffective interventions. That is not acceptable. We recommend that a better approach would be to provide guidance to civil society and academia not to enter into formal or informal partnerships with industry and explicitly state that alcohol industry funding should not be accepted.

22. Further, in the absence of a legally binding health treaty (discussed next), Member States should be encouraged to adopt measures to increase transparency of commercial influence in policy making. Member States could be advised to:

- Develop explicit agreements or protocols regarding engagement with commercial stakeholders on alcohol policy issues;
- Monitor media coverage of industry-related issues as well as industry websites;
- Identify state-funded organisations and activities sponsored by those with alcohol industry interests;
- Develop and implement regulations that require commercial operators to submit sales data as well as marketing data; and
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d) Only a legally binding treaty will meaningfully reduce the influence of commercial interests in policy making

23. The working document states: “Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant global impact on population health that is not controlled at the international level by legally-binding regulatory frameworks”, as did the 2018 Global Status Report.

24. The Coalition believes a stronger global plan and a legally binding framework, akin to the Framework Convention on Tobacco Control (FCTC), are urgently needed to support individual member states to withstand the industry's opposition to regulation, and to prioritise action on alcohol, as has been advocated previously.

Other comments

25. The Coalition supports broadening of the section 'Setting the Scene' to include the current projections of increases in consumption and harm, and the corporate strategies of transnational alcohol corporations, including their targeting of LMICs to achieve sales growth. Unregulated alcohol marketing on digital platforms is also an influential part of the commercial environment in which this plan will be operating, and should be included. This is a challenge which highlights the need for action to be truly global.

26. Normalisation of alcohol use: Health Coalition Aotearoa would like to see the Working Document recognise the many cultures (whether based on ethnicity, religion, age or peer group) who have not normalised use of alcohol. In cultures and societies where alcohol is used, this has often traditionally been small scale home production that is now being replaced by commercial alcohol and aggressive marketing by transnational corporations, leading to increased consumption and harm. Especially in LMICs, this is placing huge burdens on governments and NGOs, through social and health services and systems.

27. More regular reporting on implementation: The Coalition is concerned about the lack of specific time periods for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to reduce alcohol harm, we ask that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

28. In addition, prior to the review of the Strategic Development Goals in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

29. We also support an increase in resourcing of the WHO Alcohol and Drugs Unit from member states to progress harm reduction and health equity with respect to alcohol.

30. Health Coalition Aotearoa thanks WHO for the opportunity to submit to this consultation.

info@healthcoalition.org.nz 3 December 2020.

References: Please refer to formatted document attached

Attachment(s): 1

00165_01_hca-submission-to-who-action-plan-3dec20.pdf

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info@healthcoalition.org.nz 3 December 2020.

References

- ¹ Viet Cuong, P., Casswell, S., Parker, K., Callinan, S., Chaiyasong, S., Kazantseva, E., ... & Parry, C. D. (2018). Cross-country comparison of proportion of alcohol consumed in harmful drinking occasions using the International Alcohol Control Study. *Drug and Alcohol Review*, 37, S45-S52.
- ² Ministry of Health. (2020). Annual Update of Key Results 2019/20: New Zealand Health Survey. Available from: <https://www.health.govt.nz/publication/annual-update-key-results-2019-20-new-zealand-health-survey>
- ³ Chambers, T., Stanley, J., Signal, L., Pearson, A. L., Smith, M., Barr, M., & Ni Mhurchu, C. (2018). Quantifying the nature and extent of children's real-time exposure to alcohol marketing in their everyday lives using wearable cameras: Children's exposure via a range of media in a range of key places. *Alcohol and alcoholism*, 53(5), 626-633.
- ⁴ Government Inquiry into Mental Health and Addiction. He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. (2018). Wellington; New Zealand.
- ⁵ Health and Disability System Review. (2020). Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR.
- ⁶ Manthey, J., Shield, K. D., Rylett, M., Hasan, O. S., Probst, C., & Rehm, J. (2019). Global alcohol exposure between 1990 and 2017 and forecasts until 2030: a modelling study. *The Lancet*, 393(10190), 2493-2502.

Health Services Executive

Department/Unit: *National Office of Health & Wellbeing*

Country/Location: Ireland

URL: <https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/alcohol-programme/>

Submission

It is critical to the Irish Health Services Executive that all elements of this proposed strategy are implemented to resource the multiple responses required to reduce alcohol related harms.

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan.

Strengths of the Action Plan include:

- The focus on the 'Implementation of High-Impact Strategies and Interventions' or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.
- The inclusion of an objective focusing on prevention and treatment capacity being an integral part of universal health coverage.
- The establishment of models of care for alcohol treatment

There are also areas where the Action Plan can be strengthened, including:

- Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization
- Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm
- Dealing with the alcohol industry in a single paragraph due to their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does.
- Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.
- Need for greater emphasis throughout the document of Harm to Others as this may be a turning point similar to the tobacco campaign where the hearts and minds of the population can be won

- Need for greater emphasis on the education and training of all health and social care staff on the screening and management of substance use presentations. This should be a priority as many professionals avoid exploration of such issues either due to their own use of substances or because of their lack of training due to seeing it as a 'specialist area'.
- Building up national monitoring systems on alcohol and health is particularly important as, similar to other countries, Ireland needs to base all actions in clear evidence of harms.

Attachment(s): 1

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Services Executive
National Office of Health & Wellbeing
4th Floor, 89-94 Capel Street,
Dublin 1, D01 P281

Marion.rackard@hse.ie

13 December 2020

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organisation (WHO)
Avenue Appia 20 1211 Geneva

Re.: Submission on the Working Document for the development of an Action Plan to strengthen implementation of the WHO Global Alcohol Strategy (Working Document)

Dear Director-General,

We are grateful for the opportunity to comment on this working document as it is a timely opportunity for this Health Service given that we recently engaged with stakeholders in a similar consultation process in 2020 to ascertain their concerns and priorities for a national alcohol implementation plan.

The Health Service Executive (HSE) Alcohol Programme is part of HSE Health and Wellbeing, Strategic Planning and Transformation and seeks to support people to achieve a healthier and safer Ireland through reducing individual and population alcohol consumption, reducing health inequalities, and protecting children, families and communities from alcohol-related harm and to improve their health and wellbeing. It was established in 2016 to bring national leadership and focus to alcohol-harm reduction, as outlined in the [Healthy Ireland framework](#). It adopts a population health approach and seeks to embed evidence-based policy into relevant services to promote a co-ordinated approach to alcohol harm reduction and to capitalise on resources and expertise across the HSE and its partners. Our work is also informed by the national drug and alcohol strategy, [Reducing Harm, Supporting Recovery: a health led response to drug and alcohol use in Ireland 2017-2025](#).

The vision for the HSE Alcohol Implementation Plan is similar to the *2010 Global Strategy to Reduce the Harmful Use of Alcohol* which is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to alcohol and the ensuing social consequences.

It is particularly important for the Health Service to have global leadership and guidance on alcohol from the WHO which is recognized and valued as a trusted source of information. Public Health and alcohol is a highly contested space and given the positive attitudes to alcohol evidenced within the Irish population it is our experience from the past four years of a prominent public health campaign entitled www.askaboutalcohol.ie that the population is willing to engage with and appreciative of HSE public health information and leadership on alcohol harm.

Leadership in this area is also critically important in seeking to prevent the alcohol industry having influence on alcohol policy within Ireland. The Department of Health and Education have also made clear statements about Alcohol Education being the sole responsibility of the Health and Education Departments bodies and not the Alcohol Industry. The HSE developed a clear communication to all staff and stakeholders re non engagement with any projects funded or developed by the Alcohol Industry social aspect organisations.

The clear messages about the WHO's 'best buys' around alcohol policy especially relating to price, marketing and availability are especially useful and formed the basis of Ireland's Public Health (Alcohol) Act 2018 which seeks to reduce Ireland's alcohol consumption.

Evidence on Alcohol in Ireland

Alcohol has major public health implications in Ireland due to our high levels of consumption, and its wide range of health and social harms. A 2011 study estimated that alcohol is responsible for approximately 90 deaths every month in Ireland and over 1,000 deaths per year.¹ Data from the Health Research Board (HRB) suggests that there are between 150,000-200,000 dependent drinkers in Ireland and 1.3 - 1.4 million hazardous/harmful drinkers in Ireland. Ireland also has one of the highest rates of binge drinking in the world, with 37% of the population reporting binge drinking in the 2018 Healthy Ireland survey.² Current annual alcohol consumption in Ireland is now at 11 litres per capita, 20% higher than the target of 9.1 litres per capita set by the Reducing Harm, Supporting Recovery Strategy. The drinking levels in Ireland are 80% above the global average and 40% above the HSE low risk drinking guidelines.

According to the World Health Organisation (WHO), the harmful use of alcohol is a causal factor in more than 200 disease and injury conditions, including cancer, diabetes, road traffic collisions, self-harm and suicide.³ Chronic alcohol-related conditions are becoming increasingly common among young age groups. Alcoholic liver disease (ALD) rates are increasing rapidly in Ireland and the greatest level of increase is among 15-to-34-year-olds, who historically had the lowest rates of liver disease.⁴ Alcohol is also a factor in half of all suicides in Ireland and is involved in over a third of cases of deliberate self-harm.⁵

¹ Lyons, S., Lynn, E., Walsh, S., Sutton, M., & Long, J. (2011). Alcohol-related deaths and deaths among people who were alcohol dependent in Ireland, 2004 to 2008. Dublin: Health Research Board.

² National Service Plan 2020

³ Alcohol Action Ireland, <https://alcoholireland.ie/facts/health-and-alcohol/>

⁴ Alcohol Action Ireland, <https://alcoholireland.ie/facts/health-and-alcohol/>

⁵ Martin, J., Barry, J., Goggin, D., Morgan, K., Ward, M., & O'Suilleabhain, T. (2010). Alcohol-Attributable Mortality in Ireland. Alcohol and Alcoholism 1-8.

A significant proportion of the population also experience harm from others' drinking. A study in 2015 found that one in six parents/guardians reported that their children experienced harm because of someone else's drinking, and half reported experiencing harm due to strangers' drinking in the past 12 months.⁶ It is estimated that over 200,000 children in Ireland are suffering from alcohol-related harm due to parental alcohol use.⁷

Just as alcohol harm impacts on many aspects of Irish life, it does so on many aspects of the health services. There are over 17,000 alcohol-related admissions and discharges from acute hospitals in Ireland every year wholly attributable to alcohol, with 17,917 alcohol-related discharges reported in 2015 amounting to 175,750 bed days.⁸ This does not account for the significant number of patients presenting to Emergency Departments not requiring admission or leaving before being assessed.⁹ Dealing with the consequences of alcohol use and misuse places an estimated burden of €3.7 billion annually on the resources of the State.¹⁰ However, evidence suggests that most people with alcohol-related problems never seek healthcare, and those that do seek formal treatment do so at a late stage after the onset of alcohol dependence. This is due to a number of reasons, including low health literacy, stigma, shame, and service availability.¹¹ Prevention and early intervention is therefore critical in order to reduce alcohol-related morbidity and mortality, and to protect children, families and communities from the harm alcohol causes to others.

Despite the negative impact of alcohol on Irish society, there are strong social and cultural norms around alcohol consumption that are deeply embedded and cannot be turned around through short-term action. Research has demonstrated that drinking above weekly recommended low risk guidelines in Ireland is considered normal and unproblematic.¹² The alcohol industry works to reinforce and exaggerate strong pro-alcohol social norms through alcohol marketing.¹³ Unpublished research conducted in 2015 by the HSE to inform the development of the Ask About Alcohol campaign found that Irish people considered that alcohol has had more of a positive than a negative impact on Ireland and Irish people's lives. The primary motivator for Irish people to drink alcohol appeared to be the opportunity it provides for social connection with peers. It enables people to connect at a perceived deeper level. Thus, the ideal outcome for drinking alcohol is connection, while the worst outcome is isolation. These social and cultural norms need to be tackled in order to reduce alcohol-related harm.

⁶ Hope, A., Barry, J., & Byrne, S. (2018). *The untold story: harms experienced in the Irish population due to others' drinking*. Dublin: Health Service Executive.

⁷ <https://alcoholireland.ie/policy/alcohol-children-and-young-people-do-we-need-be-concerned/>

⁸ Mongan, D., & Long, J. (2016). *Overview of alcohol consumption, alcohol-related harm and alcohol policy in Ireland*. HRB Overview Series 10. Dublin: Health Research Board.

⁹ McNicholl, B., Goggin, D. & O'Donovan, D., Alcohol-related presentations to emergency departments in Ireland: a descriptive prevalence study, *BMJ Open*. 2018; 8(5): e021932.

¹⁰ Byrne S. (2010). *Costs to Society of Problem Alcohol Use in Ireland*. Dublin: Health Service Executive.

¹¹ Lubman, D.I., Grigg, J., Manning, V. *et al.* (2019). A structured telephone-delivered intervention to reduce problem alcohol use (Ready2Change): study protocol for a parallel group randomised controlled trial. *Trials* **20**, 515 (2019).

¹² Hope, A., Barry, J., & Byrne, S. (2018). *The untold story: harms experienced in the Irish population due to others' drinking*. Dublin: Health Service Executive.

¹³ Hastings, G., & Angus, K. (2009). *Under the influence: the damaging effect of alcohol marketing on young people*. British Medical Association.

A Cancer Strategy has been established in countries for the past 30 years providing people with screening, brief intervention and treatment depending on the severity of presentations, delivered by highly qualified staff. Equally alcohol related problems span a wide continuum of physical and social harms and highly trained staff with relative competencies and skills are required to provide standardised models of care. Treatment of various levels of dependency should be regarded as a human right to preserve life and avoid premature deaths and reducing the impact of harm to others.

An effective Action Plan is needed to strengthen the Global Strategy

The implementation of the Global Strategy has been uneven across the WHO regions. Between 2010 and 2018 no tangible progress was made in reducing total global alcohol consumption per capita. Implementation of the alcohol policy best buy solutions has been insufficient in most countries around world over the last ten years. The alcohol industry has continued to interfere in alcohol policy-making processes. Therefore, the overall burden of disease attributable to alcohol consumption remains unacceptably high. In 2016, alcohol caused three million deaths worldwide. Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. Without a clear Action Plan, the Global Strategy will remain unrealized and the health, social, economic and development harms of alcohol consumption will remain high and continue to be an obstacle to achieving the Sustainable Development Goals.

We have reviewed the Working Document for the development of an action plan to strengthen implementation of the WHO Global Alcohol Strategy (WHO GAS) and have the following comments and suggestions for your consideration:

Strengthening the Action Plan

The Working Document provides a sound starting point for the development of an Action Plan. Strengths of the Action Plan include:

- The focus on the '*Implementation of High-Impact Strategies and Interventions*' or SAFER strategies.
- The inclusion of global targets and indicators.
- The acknowledgement of the need to increase resources required for action.
- The inclusion of an objective focussing on prevention and treatment capacity being an integral part of universal health coverage.
- The establishment of models of care for alcohol treatment.

There are also areas where the Action Plan can be strengthened, including:

- Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization.
- Ensuring greater focus on the SAFER strategies to ensure that limited resources can be used to have the greatest impact in reducing harm.
- Dealing with the alcohol industry in a single paragraph due to their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy; the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does.

- Having a greater focus on governance and infrastructure improvements, resourcing, as well as review and implementation.
- Changing the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use and 'economic operators', which does not clearly articulate the significant financial and vested interest that alcohol corporations and lobby groups have in increasing the sale of alcohol.
- Need for greater emphasis throughout the document of Harm to Others as this may be a turning point similar to the tobacco campaign where the hearts and minds of the population can be won.
- Need for greater emphasis on the education and training of all health and social care staff on the screening and management of substance use presentations. This should be a priority as many professionals avoid exploration of such issues either due to their own use of substances or because of their lack of training due to seeing it as a 'specialist area'.
- Building up national monitoring systems on alcohol and health in order to base actions in clear evidence of harms.

The action plan sets out many of the elements required to provide an equitable response to the level of alcohol related harms in society. Each action in this Global Strategy is critical to our health service in its ability and capacity to respond to the significant numbers of health and social harms due to alcohol which occupy every aspect of the health services particularly acute hospitals and chronic disease management structures.

Signalling a major impairment to progress and with previous experience of the Global Tobacco Industry, an important statement in 2013 by Dr. Margaret Chan Director General of the WHO outlined the following during her opening address at the Global Alcohol Policy Symposium, https://www.who.int/dg/speeches/2013/global_alcohol_policy_symposium_20130426/en/

"Tactics include front groups, lobbies, promises of self-regulation, lawsuits and industry-funded research that confuses the evidence and keeps the public in doubt. This is formidable opposition. Market power readily translates into political power. Few Governments prioritize health over big business... Tactics also include gifts, grants, and contributions to worthy causes that cast these industries as respectable corporate citizens in the eyes of politicians and the public. They include arguments that place the responsibility for harm to health on individuals, and portray government actions as interference in personal liberties and free choice."

Thank you for your consideration of this submission and looking forward to receiving the next iteration of the 2030 Global Alcohol Strategy.

Yours sincerely,

Marion Rackard
 Project Manager
 On behalf of the Health Services Executive Alcohol Programme

Healthy Caribbean Coalition

Country/Location: Barbados

URL: <https://www.healthycaribbean.org/>

Submission

A. Role of economic operators:

In the current document the “economic operators” – i.e., alcohol industry entities (producers, distributors, retailers, etc) – are listed as stakeholders in equal standing alongside civil society and other UN organisations. This is of great concern to those of us in the Caribbean where the alcohol industry is historically positioned to have the ear of politicians and the lobby vigorously to affect rules, laws and regulations.

The alcohol industry should, instead, be addressed in a separate section with due regard to conflict of interest toward safeguarding public health.

B. Focus on WHO best buys/SAFER

The numerous and sometimes overlapping recommendations in the draft document tend to obscure a focus on the most cost-effective policies to reduce alcohol-related harms. The Action Plan should be strongly framed around every country implementing the 5 most effective, science-based interventions, as articulated in the SAFER guidance: Strengthening restrictions on alcohol availability; Advancing and enforcing drink driving counter measures; Facilitating access to screening, brief interventions, and treatment; Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship, and promotion; and raising prices on alcohol through excise taxes and pricing policies. The monitoring indicators should include specific metrics of SAFER implementation, and countries’ reporting of the implementation of SAFER policies should be facilitated. The Caribbean would benefit from such mandates being promoted by the WHO; this would provide an impetus for small states to adopt such regulations, even in the face of lobbying by the alcohol industry.

C. Limited Resources to conduct research, educational activities and monitoring of the alcohol industry in LMIC

The disproportionate prevalence of effective alcohol control measures in higher-income countries raises questions about global health equity; it underscores the need for more resources and greater priority to be allocated to support the development, implementation and monitoring of effective policies and actions in low- and middle-income countries; and even in higher income countries that lack the legislative infra-structure and civil society oversight to counter-balance the effects of the alcohol industry.

D. Lack of legally binding regulatory instruments at the international level

The WHO document reports: Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the

international level by legally-binding regulatory instruments. The HCC supports this observation and the 'calls for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control.'

Attachment(s): 1

00249_44_statement-hcc-30nov2020.pdf



Statement from Healthy Caribbean Coalition regarding WHO consultation on the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

01 December 2020

We, at the Healthy Caribbean Coalition, have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration:

Role of economic operators:

In the current document the “economic operators” – i.e., alcohol industry entities (producers, distributors, retailers, etc) – are listed as stakeholders in equal standing alongside civil society and other UN organisations. This is of great concern to those of us in the Caribbean where the alcohol Industry is historically positioned to have the ear of politicians and the lobby vigorously to affect rules, laws and regulations.

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Lack of legally binding regulatory instruments at the international level

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For more information:

Healthy Caribbean Coalition: Executive Director: Ms Maisha Hutton 246 435 7486



The Healthy Caribbean Coalition (HCC) was informally established in 2008, arising out of the 2007 Declaration of Heads of Government of the Caribbean Community (CARICOM) on non-communicable diseases (NCDs). Its stated vision is to harness the power of civil society, in collaboration with government, academia, and international partners, and private enterprise as appropriate, in the development and implementation of plans for the prevention and management of chronic diseases among Caribbean people. The HCC was officially registered as a not-for-profit organisation in 2012. The HCC is the only Caribbean NCD alliance of over 100 health and non-health civil society organisations (CSOs). We work closely with regional and international leaders in NCD prevention and control to leverage the power of civil society by strengthening and supporting its membership in the implementation of programmes aimed at reducing the morbidity and mortality associated with NCDs.

Healthy Lanka

Country/Location: Sri Lanka

URL: www.healthylanka.lk

Submission

Healthy Lanka is a Sri Lanka organization working on alcohol and drug prevention, gender justice and child rights while strengthening the civil society. We support the WHO effort on establishing a global strategy to control alcohol use.

We propose that to use the word "alcohol use" instead "alcohol misuse" just as WHO uses "tobacco use" not "tobacco misuse" in documents.

We propose the any government allowing alcohol industry to produce, distribute or sell alcohol violates the human rights recognized in Universal Declaration of human rights specially the articles 1,3,4, 5,6,7,8,9,12,16,17,18,19,22,23,24,25,26 and 27, firstly there is no beneficial effects in the recreational use of ethanol and the health , economic and social impact of alcohol use is devastating.

We propose that under Action Area 1, effective prevention education has to be included specially using the expectancy challenge models. Expectancy challenge education is a proven practice in South Asia, South east Asia and African context as these regions put more weight on prevention education strategies. We have attached file one to elaborate this expectancy challenge model.

We suggest, that Community Action has to be included in Action Area 1 as reducing the attractiveness of the image of alcohol as a prevention and treatment strategy could be achieved through evidence based Community Interventions. Other than advocacy, this community interventions has produced results in alcohol tobacco and drug demand reduction endeavors specially in Asian, African and Latin American settings.

More men than women are vulnerable to alcohol use and to develop severe health and social problems. Therefore challenging masculinities and femininities is an essential component in prevention and treatment efforts to reduce alcohol related problems. We propose challenging of masculinities and femininities has to be included in one of the Action areas as a strategy.

Attachment(s): 2

00288_56_shakya-nanayakkara-1.pdf

00288_57_shakya-nanayakkara-4-1.pdf

Heartland Alliance International

Department/Unit: *Programs Department*

Country/Location: Nigeria

Submission

* To make social norms campaigns and alcohol control policies more effective, alcohol reduction strategies should be developed to counter the powerful influence of alcohol marketing and promotions.

* It should be noted that many low income countries seem to be largely on their own in seeking to control their national alcohol markets and limit the damage from drinking; and many of such policies have been eroded at the national and subnational levels. A crucial political support is needed.

Attachment(s): 1

00470_06_abstract.pdf

Ogbonna Chinwe Belinda

Heartland Alliance International- Nigeria

Abstract

Alcohol use is a major contributing factor to the global burden of disease as well as one of the leading risk factors for diseases, injury conditions, adverse health conditions and death among young and middle-aged men and women in low, middle and high income countries. Harmful use of alcohol can have serious health, social and economic consequences both for the drinker and for others around the drinker, and for societal development. Although harmful use of alcohol among young people has been widely discussed in western countries, little attention has been paid to low income countries.

Alcohol policy is generally designed to reduce drinking and risky drinking situations. While recognizing the fact that social media provides new opportunities for changes in peoples' relationship with alcohol through increased awareness of the adverse health consequences of drinking, it also has its negative influences and effects. To make social norms campaigns and alcohol control policies more effective, alcohol reduction strategies should be developed to counter the powerful influence of alcohol marketing and promotions.

Subsequently, the W.H.O has recommended five "best buys" – the most cost-effective policy interventions to tackle harmful use of alcohol in the national context, including specific buys such as restricting access to retail alcohol, tax increase on alcohol and imposing bans on alcohol advertising. However, it should be noted that many low income countries seem to be largely on their own in seeking to control their national alcohol markets and limit the damage from drinking; and many of such policies have been eroded at the national and subnational levels. A crucial political support is needed.

Key words: Alcohol policy, national intervention, low-income countries, adverse effects, policy making

Hellenic Association of Brewers

Country/Location: Greece

URL: www.ellinikienosizithopoion.gr

Submission

Hellenic Association of Brewers

The brewing sector in Greece is one of the few sectors in the wider alcoholic beverages category that has been consistently implementing important initiatives to promote the responsible consumption of alcohol and to decrease the harmful use of alcohol.

There are several actions related to responsible drinking alcohol consumption, driven by members of the Hellenic Association of Brewers in collaboration with authorities and NGOs.

Indicatively, to mention:

Responsible drinking indication in all our products, both on pack and online

Activations and consumer campaigns regarding the avoidance of alcohol consumption when driving, swimming & participating in water sports, underage drinking etc.

Even more prominent though, is the increased focus of the industry in providing customers and consumers with low & no alcohol beer options. This is totally proven by the market facts: non alcoholic beer in Greece is growing with a CAGR of 40% between 2013 and 2019, whereas in the same period total beer market has been practically stable, fluctuating between 3.8 & 4.0 mil hls. Overall, the total low & no alcohol segment has grown 7 times in volume during the same period, representing now 3% of the total market (source: Global Data report 2019). Moreover, the non alcoholic beer segment has been constantly advertised disproportionately vs the rest of the category, demonstrating the willingness of all the local brewers to enhance its role in the market. The share-of-voice of all non alcoholic beer brands and line extensions in TV (still main communication medium in Greece) was 21% in 2019 and 25% in 2020. (source: Media Services 2019/2020). Additionally, several activations have been taking place with the objective to widen the range of alcohol-free beer consumption, i.e., related with sports, lunch at work, health & wellness etc.

Attachment(s): 0

Hong Kong Alliance for Advocacy Against Alcohol

Country/Location: China

URL: <http://www.hkccm.org.hk/>

Submission

1. Economic operators with a stake in alcohol sales have mission and vision that fundamentally conflict with those of the Global Strategy. They have no role in developing or influencing the formulation of this action plan, or for that matter, development, implementation and evaluation of alcohol policy at global, national and local levels. They are not, and should not be construed as, equivalent to other 'non-state actors' in the context of the action plan. Neither is there a need to 'invite' them to self-regulate or act contrary to their profit-driven goals and objectives.
2. Implementation of WHO's SAFER initiative is seriously impeded by interference from transnational commercial interests. WHO should set out in the action plan immediate, concrete steps and timeline to formulate a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control, to regulate the distribution, sale and marketing of alcohol within the context of international, regional and bilateral trade negotiations, as well as to protect the development of alcohol policies from interference by transnational corporations and commercial interests.
3. WHO secretariat, Member States, public funded bodies and research institutions, and civil societies should stop dialogue with economic operators which have a stake in alcohol sales.
4. WHO should lead a global exercise to stock take pervasive commercial interference of economic operators in public policy making and anti-alcohol efforts at transnational, national and local levels.
5. WHO should initiate annual alcohol awareness drives lasting days in the least, and incorporate behaviour change in these drives.
6. WHO should call for biennial publishing of national status reports on alcohol and health, and biennial reporting by action parties in accordance with SMART objectives.
7. The term "harmful use of alcohol" in the action plan is misleading and confusing for the purpose of public education, and should be replaced by "alcohol related harm".

Attachment(s): 1

00170_14_hkaaaa-submission20201203.pdf

Hong Kong Alliance for Advocacy Against Alcohol

Position Paper on the WHO Consultation Document on the Global Action Plan

We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration:

1. The Hong Kong Alliance for Advocacy Against Alcohol (HKAAAA) welcomes World Health Organization's move to develop an action plan to strengthen the Global Strategy to reduce harms related to alcohol use.
2. The HKAAAA understands the Global Strategy was set out to support and complement public health policies in Member States at national and local levels to achieve considerable reduced morbidity and mortality as well as improved health and social outcomes for individuals, families and communities, but notes that globally, the levels of alcohol consumption and alcohol-attributable harm continue to be unacceptably high.
3. The HKAAAA agrees that considerable challenges for the development and implementation of effective alcohol policies relate to the complexity of the problem, differences in cultural norms and contexts, intersectoral nature of cost-effective solutions and limited political will and government leadership, but considers the influence of powerful commercial interests especially from transnational alcohol companies to be exerting the greatest negative influence of all.

4. Economic operators with core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages, have primary commercial responsibilities to their shareholders and must therefore rely on substantial sales either by encouraging heavy drinking or engaging more people to drink, many of whom belong to vulnerable and marginalised groups such as young people, less educated, unemployed, people who are stressed out or suffer from mental ill health, and so on. As such, economic operators have mission and vision that fundamentally conflict with those of the Global Strategy. The HKAAA is of the view that these economic operators should have no role in developing or influencing the formulation of this action plan, or for that matter, development, implementation and evaluation of alcohol policy at global, national and local levels. These economic operators are not, and should not be construed as, equivalent to other ‘non-state actors’ in the context of the action plan. Neither is there a need to ‘invite’ them to self-regulate or act contrary to their profit-driven goals and objectives.

5. As WHO rightly points out, alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments. The HKAAA urges WHO to set out in the action plan immediate, concrete steps and timeline to formulate a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control, to regulate the distribution, sale and marketing of alcohol within the context of international, regional and bilateral trade negotiations, as well as to protect the development of alcohol policies from interference by transnational corporations and commercial interests.

6. The launching of WHO's SAFER initiative comprising the most cost-effective actions or "best buys", namely, increasing taxes on alcoholic beverages, enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media, and enacting and enforcing restrictions on the physical availability of retailed alcohol, is applauded. However, the HKAAAA considers that political will, government leadership and intergovernmental commitment aside, interference from transnational commercial interests needs to be kept at bay, through global regulatory efforts initiated, coordinated and assured by WHO.
7. The HKAAAA recognises that in today's world that favours free trade, a legally binding regulatory framework provides the bottom line for economic operators in alcohol production and trade as well as operators in other relevant sectors to eliminate marketing and advertising of alcoholic products to minors and other vulnerable groups, prevent heavy drinking, eliminate false health claims, and ensure availability of easily-understood consumer information on the labels of alcoholic beverages (including composition, age limits, health warning and contraindications for alcohol use).
8. The HKAAAA further points out the term "harmful use of alcohol" used repeatedly throughout the consultation document implies there are beneficial uses of alcohol, which practically do not exist. This misperception is, to a large extent, influenced and reinforced by commercial messaging and

poorly-regulated alcohol marketing which deprioritize efforts to counter the harms of alcohol use. This has resulted in low awareness and poor acceptance of the overall negative impact of alcohol consumption on a population's health, safety and wellness among decision-makers, general public and even health care providers. Moreover, it confuses the public and hinders education efforts. The HKAAA calls on WHO to stop using the term "harmful use of alcohol" and adopt "alcohol related harm" in its place.

9. To reduce interference from commercial interests, the HKAAA calls on all types of dialogue between economic operators with a stake in alcohol and public institutions (WHO secretariat, Member States, public funded bodies and research institutions, and civil societies) be halted and reduced to a minimum, and if they must go ahead, be documented with respect to the purpose, parties involved, mode, content, expenses and outcome for the sake of transparency and public accountability.
10. To help expose and recognize pervasive commercial interference in public policy making and anti-alcohol efforts including 'corporate social responsibility' initiatives at transnational, national and local levels in order that public and non-profit organisations may steer clear of commercial interests of economic operators, the HKAAA requests the WHO to take the lead in a global stock taking exercise that will also serve as baseline for future regulatory work.
11. The HKAAA recommends the setting of SMART (specific, measurable, achievable, relevant and time-bound) objectives relating to all recommended or proposed action within the action plan.

12. The HKAAA suggests biennial publishing of national status reports on alcohol and health, and biennial reporting by action parties to help focus global, national and local anti-alcohol efforts, and strengthen monitoring and public accountability.

13. To counteract alcohol marketing in the form of recurrent wine and dine promotions, sports sponsorships and the like, which are often held for days and weeks in a row, HKAAA supports the WHO to initiate global efforts to organize annual national alcohol awareness drives. HKAAA, however, considers these drives should last for at least 5 to 7 days, and incorporate health behavior changes on top of raising awareness. Examples may include public and non-public institutions refraining from serving alcohol at business and private occasions, making pledges to reject alcohol sponsorships, and strengthening support for drinkers who anticipate quitting.

Dated 3 December 2020

- END -

House of Hilkiah Foundation

Country/Location: Nigeria

URL: <https://houseofhilkiahfoundation.org>

Submission

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden

we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

With the 7 Points for Action Plan Improvement.

- 1.Ensure bold targets and ambition
- 2.Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
- 3.Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
- 4.Ensure greater focus on the SAFER strategies;
- 5.Ensure greater focus on governance and infrastructure improvements;
- 6.Improve resourcing as well as reporting and review of implementation; and
- 7.Update nomenclature in line with state-of-the-art evidence

The targets and action plan have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

Attachment(s): 1

00444_76_1movendi-members-who-working-doc-consultation.pdf



Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

House of Hilkaiah Foundation is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

House of Hilkaiah Foundation (HOHF) is a Nigerian-based Non-governmental, Non-profit, and Non-Political Organization birthed with the goal of empowering women and providing formal and informal educational support for young girls as well as for youths. House of Hilkaiah Foundation is working on achieving Goal Three of the SDGs Goals in the area of Alcohol and Drug Abuse Prevention

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

- A. 7 Points for Action Plan Improvement
 1. Ensure bold targets and ambition
 2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
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 5. Ensure greater focus on governance and infrastructure improvements;
 6. Improve resourcing as well as reporting and review of implementation; and
 7. Update nomenclature in line with state-of-the-art evidence.

- B. Additional point to be added to the action plan

1. Suggestion for elements of the action plan
- C. Point of criticism and request for significant change
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A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome – and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument

2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world's children. The WHO–UNICEF–Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children's health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and

- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

Where possible, actions and key indicators should be time-bound.

4. Ensuring greater focus on the SAFER strategies

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions – to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol.

We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys – that has largely fallen short of necessity – is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document.

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements – learning lessons from other health areas.

Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.

2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.
7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings – like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals – like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO’s expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

Regarding the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called “Infrastructure”.

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential – as tobacco control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden.

For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level.

We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through "SAFER pilot countries".

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial – both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets

2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.

3. Framework for action

Operational objectives: 8

Priority areas for global action: 6

Global action: WHO

National action: Member States

4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Independent Order of True Templars (I.O.T.T)

Department/Unit: *Transvaal and Swaziland Borders Grand Temple*

Country/Location: South Africa

URL: <https://iottsa.co.za/>

Submission

The Independent Order of True Templars (IOTT), Southern Africa is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

Attachment(s): 1

00493_17_movendi-members-who-workingdoc-consultationiott.pdf

Submission - WHO Consultation - Working Document to develop an action plan for improving WHO GAS* implementation

The Independent Order of True Templars (IOTT), Southern Africa is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

The Independent Order of True Templars (I.O.T.T.) is an organization based on open membership from different denominations. It is also good to acknowledge that "Prayer" is its motivational and experiential source for spiritual growth. I.O.T.T. is also a non-denominational Christian organization fighting with the consumption of alcohol and drugs on the Methodism of Templarism.

I.O.T.T. recognizes that alcohol and other drug constitute a serious threat to the dignity and freedom of people and their societies. As part of the solution to alcohol and drug problems, members of I.O.T.T. choose to lead a life free such substances.

I.O.T.T. furthermore, develops comprehensive programs that includes prevention, reduction of substance use, education, communication, training, public awareness, research, and the rehabilitation of users and those they affect.

Currently the I.O.T.T exists In the following countries In Southern Africa: The Kingdom of Lesotho, Botswana, Zimbabwe, The Kingdom of Eswatini, South Africa and Mozambique, with a membership of 11 000.

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition
 2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
 3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
 4. Ensure greater focus on the SAFER strategies;
 5. Ensure greater focus on governance and infrastructure improvements;
 6. Improve resourcing as well as reporting and review of implementation; and
 7. Update nomenclature in line with state-of-the-art evidence.
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Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

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Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

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Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements - learning lessons from other health areas.

Regarding the level of global action:

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Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called "Infrastructure".

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We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

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B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

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2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.
3. Framework for action
Operational objectives: 8
Priority areas for global action: 6
Global action: WHO
National action: Member States
4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption

while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

INESS Institute of Economic and Social Studies

Department/Unit: *Regulations*

Country/Location: Slovakia

URL: www.iness.sk

Submission

It is true that states' spending on education and prevention falls far short of the revenues they derive from alcohol taxation. It is therefore justified to require states to seek earmarking opportunities for these taxes in order to meet their obligations while at least partially compensating for the direct externalities caused by harmful alcohol consumption. Due to the non-use of existing resources, we consider the proposal to increase the volume of resources with new types of fees or taxes to be inappropriate. For the same reason, we do not agree with the proposal to discuss a global alcohol tax. In addition, the global tax would lead to efforts to establish a transnational harmonized anti-alcohol policy led by nonelected experts. Such an approach would lack the standard requirement of a democratic society for political responsibility for misconduct. The shortcoming of any harmonization is the disregard for regional cultural differences, which play an important role (in alcohol consumption in this case). The existence of these differences is also the reason why we do not agree with the introduction of percentage reductions in alcohol consumption per capita. The primary goal of these policies should persist to be the reduction of costs caused by harmful consumption of alcohol, instead of decreasing total consumption per capita.

Attachment(s): 1

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Summary

It is true that states' spending on education and prevention falls far short of the revenues they derive from alcohol taxation. It is therefore justified to require states to seek earmarking opportunities for these taxes in order to meet their obligations while at least partially compensating for the direct externalities caused by harmful alcohol consumption. Due to the non-use of existing resources, we consider the proposal to increase the volume of resources with new types of fees or taxes to be inappropriate. For the same reason, we do not agree with the proposal to discuss a global alcohol tax. In addition, the global tax would lead to efforts to establish a transnational harmonized anti-alcohol policy led by nonelected experts. Such an approach would lack the standard requirement of a democratic society for political responsibility for misconduct. The shortcoming of any harmonization is the disregard for regional cultural differences, which play an important role (in alcohol consumption in this case). The existence of these differences is also the reason why we do not agree with the introduction of percentage reductions in alcohol consumption per capita. The primary goal of these policies should persist to be the reduction of costs caused by harmful consumption of alcohol, instead of decreasing total consumption per capita.

Action Area 1 : Global target 1.2 Reduction of alcohol consumption per capita

Compared to Slovakia (9.7 l per person), alcohol consumption per person in France reaches 11.7 l, i.e. 20 % higher. Nevertheless, the risk of death from alcohol use disorders is lower in France. Likewise, the DALY (Disability-Adjusted Life Year) indicator is 34 % lower in France than in Slovakia. Therefore, we think that the decrease in absolute alcohol consumption per capita as proposed in global target 1.2 should not be defined. The second reason is the fact that it is not the role of the government to prevent an individual from engaging in self-destructive behaviour, but to ensure awareness of its adverse consequences, or to ensure payment for induced externalities. Each behaviour brings many benefits, the value of which experts and politicians cannot know, and thus the resulting cost-benefit analysis is possible only at the level of each individual.

The third reason is the economic aspect of non-excessive alcohol consumption. For example, in the Czech Republic there was an increase in the number of small and medium-sized breweries by 263 % in the period 2001 - 2019. These became a part of a new phenomenon, the so-called beer tourism, which increases the share of tasting and reduces the share of excessive drinking and brings positive benefits to other tourism enterprises in the area. This dramatic increase in the number of mini-breweries was also accompanied by an absolute decrease in alcohol consumption per capita in the Czech Republic, by 8 % over the last 10 years. The implementation of significantly stricter policies, as described by the SAFER initiative, would lead to economic losses.

From a public health perspective, it remains important to focus on tackling issues such as alcohol harmfulness, excessive drinking and reasonable preventing initiation of drinking among children and adolescents. It would be desirable for the WHO to focus in its action plan on supporting the member states specifically in these areas, and thus use its policies to push the member states to a real, not just proclamatory fulfillment of the Principle 6: „Individuals and families affected by the harmful use of alcohol should have access to affordable and effective prevention and care services.“ Although it is well known that regular visits or consultations with a general practitioner contribute to reducing excessive drinking, few governments dedicate sufficient resources derived from alcohol taxation for this purpose.

Pay for your costs instead of resource mobilization

Action area 6: Resource mobilization

The new action plan calls for the mobilisation of resources to finance the activities that would decrease the impact of harmful alcohol consumption. At this point, it is only possible to agree that, especially in developed countries, expenditure on the financing of these activities is a negligible item compared to the amount of resources they derive from alcohol taxation. In the case of Slovakia, it is not even possible to trace the volume of costs for the [Action Plan to Combat Problems Related to Alcohol](#), and as a memento of this situation we can give the following example. The government did not find funds in the budget for the publication of a professional handbook for people working in the prevention of alcohol addiction. Therefore, the Ministry of Health tried to obtain sponsorship from the state health insurance company. It refused to support the handbook, so in the end it was not published at all. We should not forget about the fact, that this all happened in a situation where the taxation of alcohol generates 285 million euros annually. However, this amount of taxes is crucial for the evaluation of the new WHO action plan.

The new action plan is considering novel forms of taxation such as „levy on profits across the value chains for alcoholic beverages, taxing alcohol advertising, or fines for noncompliance with alcohol regulations “. Such proposals are absolutely unacceptable because they mean nothing less than an increase in the overall tax burden. Public administration, or, more precisely, a democratically elected political representation that is unable to earmark even a tenth of the current revenue from alcohol taxation for prevention makes clear what a “high priority” these activities are in the structure of its spending. Thus, the novel forms of taxation are, in fact, becoming only a politically practicable tool for increasing both rate of redistribution and the government's impact on citizens' lives.

However, any additional taxation on alcohol should reflect the basic economic principle that, where possible, the perpetrator should pay for the damage incurred. Thus, the real cost of the damage (not fictitious, such as the loss of GDP) would not be paid by other members of society, but by the consumer. Excise duty largely secures this and affects consumers with excessive consumption more than consumers with moderate consumption. Economic analyses, for example in the case of the Czech Republic¹, shows that the collection of taxes on alcohol, wine and beer covers health expenditures on 26 main diagnoses related to alcohol consumption. Any increase in alcohol taxation should therefore be justified by an increase in direct externalities, and we therefore call on the WHO to require states to quantify the direct health costs related to alcohol consumption in the draft action plan. Here, we would like to point out that the inclusion of indirect costs - absence from work and the resulting loss of GDP or the judicial costs - is contrary to the original idea. Absence from work is a private expense of the consumer - the voluntary absence from work does not impose additional costs on society. An individual is the sole owner of his outputs, therefore his non-work is not the source of extra costs for the society. Everyone “prepays” the judiciary services as a part of his general taxes. Just like we cannot include the costs of traffic accidents which are already financed by insurance schemes.

However, we see the biggest peril of the draft action plan in the consideration of a global alcohol tax. First, it is highly unlikely that countries would be willing to reduce their tax revenue in favour of the WHO, and as a result, the WHO would cause an increase in the tax burden for which it has no mandate. Secondly, this proposal runs counter to the fact that different countries are dealing with different problems related to harmful alcohol

¹ <http://www.iheta.org/p69-spolecenske-naklady-konzumace-alkoholu-v-ceske-republice-report>

consumption. A harmonized approach to taxation would significantly complicate the need for an individual approach. The WHO has no political responsibility for erroneous spending decisions, so it is not appropriate that it should decide on the use of tax revenues. WHO should stick to the principle that policies should be sensitive to national, religious and cultural contexts.

Radovan Ďurana
radovan.durana@iness.sk

Institut économique Molinari

Country/Location: Belgium

URL: <https://www.institutmolinari.org/>

Submission

The WHO working document for the new Global Alcohol Strategy states that “The most cost-effective actions, or “best buys”, include increasing taxes on alcoholic beverages, enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media, and enacting and enforcing restrictions on the physical availability of retailed alcohol.”

Such an approach should take into account several aspects of such policies that might counteract its aim to deliver better health and could actually have some ill intended effects.

- Substitution effect

If, public health is the stated aim of sin taxes, a number of reasons explain why this aim is not usually achieved in reality. Instituting a tax may actually have unexpected effects. While official sales of an overtaxed product clearly are likely to decline, consumers tend to substitute other products that may be just as harmful as the targeted product, or more so. This ends up compromising fulfilment of the health goals put forth by public authorities. The U.S. experience with soda taxes shows, for example, that consumers — children and teenagers especially — switch to other high-calorie drinks that are relatively inexpensive, meaning there is little or no effect on excess weight and obesity. When public authorities start taxing fat, as in Denmark in 2011, consumers increase their cross-border purchases and turn to less expensive products that may present just as great a health risk in case of excess consumption, or even a greater risk due to lower quality.

The same phenomenon affects alcohol, with taxes driving consumers toward cheaper and stronger alcoholic drinks or possibly toward the use of other drugs such as cannabis instead of alcohol. Taxes on alcoholic drinks may even cause consumers to turn to the use of illicit drugs, such as cannabis. Again, lower alcohol sales do not necessarily produce better results in health terms. Finally, despite the ineffectiveness of sin taxes, the drawbacks set out above may serve to make things worse. It remains politically tempting to attribute this ineffectiveness to the notion, for example, that the increases may not have been high enough or that they fail to affect all drinks in the same way. Taxes on alcohol therefore risk spreading to all categories of alcoholic drinks, including wine, and then rising continuously and repeatedly.

Besides, while sales of alcoholic drinks may in fact decline due to taxation, penalising the entire sector along with consumers as a whole, this risks producing a series of adverse effects. First, these taxes make no distinction between “responsible” consumers, who drink in moderate quantities, and those whose alcohol consumption is abusive. Abusive drinkers are known not to be highly sensitive to price increases, and it is mostly moderate drinkers who end up reducing their consumption. As such, this phenomenon reduces the effectiveness of taxes as a tool in the fight against alcoholism.

- Specific tax measures: a cause of illegal trafficking and parallel markets

The tax burden explains the contraband trade in certain products, even though these products are permitted on the official market. As long as taxes account for a high share of the final price, opportunities for profit are provided in the underground economy, which moves in on a long-term basis and comes to account for a significant share of countrywide sales.

Increasing this tax burden can only increase the disconnection between the real production cost of goods and their price on the official market, to such a degree that consumers begin abandoning the official market on a larger scale.

For example, the contra band sale of alcohol or tobacco products in a country such as the United Kingdom, where excise taxes alone could amount to eight euros for a 70-cl bottle of spirits, the share held by the illicit market was estimated at 13% of the official market in 2010-11.

There can be no mistake: it is not alcohol or cigarettes as such that give rise to this shadow supply. The existence of taxes on various drinks (soda and beer) and food items (sugar, chocolate, ice cream, saturated fat) had the same effect in Denmark: many Danes abandoned the domestic market and stocked up in other countries.

- Tougher repression: a self-defeating solution

Given the scope of the underground economy, public authorities generally suggest toughening the means of repression so as to collect more tax revenues. The justification for this repression remains the same: it would promote the transfer of all under-ground activity to the legal market, thereby creating new tax revenues. Beyond the cost of this repression in terms of resources and bureaucratisation of the economy, this reasoning and the resulting forecasts are erroneous. Though certain activities may no longer be undertaken in the underground economy, they will not be undertaken in the official economy either — in part or even in whole, depending on the specific case — because of the burden of compulsory levies and regulations. With prices higher, demand for the goods or services concerned will decline.

Another way of approaching this issue is to recognize that the underground economy and the official economy are closely linked and are interwoven with one another. Each depends on the value and the purchasing power created in the other. For example, nearly two-thirds of the income earned in the shadow economy is estimated to be spent in the official economy. Increased repression by the public authorities, without any change in regulatory and tax frameworks, risks simply destroying economic activities and the associated revenues. The only long-lasting solution for ending the underground economy consists of dealing with the causes that give rise to it and thus to free the official market from its fiscal and regulatory burdens. The Danish government made the politically difficult choice of following this solution in the face of parallel trade and the adverse effects caused by tax measures. It abolished its fat tax in 2012.

- The “yellow vest” effect: the role of indirect taxes in bringing tax revolts.

Policymakers should be aware that a high concentration of taxation on specific products might fuel revolts. This concentration is indeed liable to generate reactions in public opinion, as shown in work by sociologists Isaac William Martin and Nadav Gabay, who analysed 475 instances of tax revolts since the 1980s. Their analysis leads them to the following conclusions. Tax revolts are, of course, related to the respective weight of the tax in question. The higher a tax’s weight as a percentage of GDP, the greater

the probability that it will become the target of a broad mobilisation, regardless of the year under consideration. More important yet, their analysis shows that tax categories that were thought to be painless (excise duties and VAT) arouse far more protests than other categories. In rich democratic countries, early in the 21st century, it is often the payers of excise duties who shout the loudest, no doubt because they come to recognise the growing weight of these duties, which they ultimately end up paying.

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Attachment(s): 0

Institute for Research and Development "Utrip"

Country/Location: Slovenia

URL: www.institut-utrip.si

Submission

The work in our country (Slovenia) for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission. As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level. See the whole submission in the attachment.

Attachment(s): 1

00491_15_who-utrip-gas-consultations.pdf

Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

Institute for Research and Development "Utrip" (UTRIP) is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

UTRIP is a non-governmental and a non-profit research institute from Slovenia. It aims to conduct research, develop, implement, monitor, and evaluate the projects and programmes in the field of youth risk behaviour, addiction prevention, health promotion, healthy lifestyle and public health advocacy. UTRIP is a member of the European Alcohol Policy Alliance (Eurocare), the Civil Society Forum on Drugs (CSFD), the International Confederation of ATOD Research Associations (ICARA), Movendi International, the Global Law Enforcement and Public Health Association (GLEPHA) etc. It has been involved in more than 25 European projects, co-financed by the European Commission. UTRIP is a national (collaborating) centre for many evidence-based prevention programmes and it leads a national network of more than 40 Slovenian NGOs and other institutions in the field of prevention »Prevention platform« (www.preventivna-platforma.si), which has been funded by the European Social Fund (ESF) and the Ministry of Health since 2009. In February 2020, the Slovenian NCD Alliance (UTRIP is one of co-founders) received the Global NCD Alliance Award for “equipping youth for NCD advocacy in Slovenia” at the Global NCD Alliance Forum in Sharjah (United Arab Emirates). Staff of UTRIP have been awarded with important awards by the European Society for Prevention Research (EUSPR), the Society for Prevention Research (SPR) and the International Society of Substance Use Professionals (ISSUP).

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

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*WHO GAS = WHO Global Alcohol Strategy



Content of the submission overview

- A. 7 Points for Action Plan Improvement:
 - 1. Ensure bold targets and ambition
 - 2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
 - 3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
 - 4. Ensure greater focus on the SAFER strategies;
 - 5. Ensure greater focus on governance and infrastructure improvements;
 - 6. Improve resourcing as well as reporting and review of implementation; and
 - 7. Update nomenclature in line with state-of-the-art evidence.

- B. Additional point to be added to the action plan
 - 1. Suggestion for elements of the action plan

- C. Point of criticism and request for significant change
 - 1. Role of the alcohol industry, conflict of interest

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.



Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome – and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence



We propose to remove three items from the description of the challenges for WHO GAS implementation:

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstinence rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.



It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world's children. The WHO-UNICEF-Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children's health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.



3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

Where possible, actions and key indicators should be time-bound.



4. Ensuring greater focus on the SAFER strategies

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions – to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol.

We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys – that has largely fallen short of necessity – is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document.

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements – learning lessons from other health areas.



Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.
7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings – like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals – like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.



Regarding the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called “Infrastructure”.

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential – as tobacco control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.



Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden.

For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level.

We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through "SAFER pilot countries".

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous, and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial – both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the 'harmful use of alcohol', and 'economic operators' greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

'Harmful use of alcohol' incorrectly implies that there are 'safe levels' of alcohol use and has been criticized by Member States and civil society alike. 'Economic operators' does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.



B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets
2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.
3. Framework for action
 - Operational objectives: 8
 - Priority areas for global action: 6
 - Global action: WHO
 - National action: Member States
4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities, and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Matej Košir, Director
UTRIP, Slovenia

Institute of Alcohol Studies

Country/Location: United Kingdom of Great Britain and Northern Ireland

URL: www.ias.org.uk

Submission

The Institute of Alcohol Studies (IAS) welcomes the 'Working document for development of an action plan to strengthen implementation of the Global Strategy to reduce the harmful use of alcohol'(AP). We share the view expressed in the document that progress on the WHO Global Alcohol Strategy (GAS) has been insufficient and uneven. As outlined the impact of alcohol remains enormous, reaching well beyond individual health consequences and contributing to violence, domestic abuse, crime, and road deaths. Yet, reducing alcohol harm is not given sufficient prominence in policy discussions and agendas across national and international levels.

We agree with the suggestion in the AP that there are early indications of the global pandemic potentially magnifying these impacts: in England, the pandemic has been met with an increase in higher risk drinking. And yet, the global response to the crisis also presents an opportunity. For many countries, COVID-19 has made clear our dependence on emergency health care, hospitals, social care, and police – all core services on which alcohol impacts and which must be protected from avoidable pressures. Furthermore, the disproportionate impact of COVID-19 on those with underlying conditions has illuminated the need to prioritise a preventative policy agenda, of which reducing alcohol harm must be a part.

This makes the AP's success in progressing the GAS essential, and we commend the bold new approach that it represents. We are, however, concerned that the enormous breadth of policies and actions covered risks some of the key priorities being lost in the complexity. We believe that a concise, simpler document with clear aims and objectives linked to well-defined targets and indicators has the best chance of making a tangible difference to the implementation of the GAS. To that end we will first provide feedback on the structure of the AP and suggest a framework that we think would improve clarity. Secondly, we will provide some suggestions on the content of the document itself.

Our full response can be found in the attached pdf.

Attachment(s): 1

00330_10_ias-response-to-who-global-alcohol-action-plan-final.pdf

IAS Response to WHO Global Alcohol Action Plan

Introduction

The Institute of Alcohol Studies (IAS) welcomes the ‘*Working document for development of an action plan to strengthen implementation of the Global Strategy to reduce the harmful use of alcohol*’ (AP). We share the view expressed in the document that progress on the WHO Global Alcohol Strategy (GAS) has been insufficient and uneven. As outlined the impact of alcohol remains enormous, reaching well beyond individual health consequences and contributing to violence, domestic abuse, crime, and road deaths. Yet, reducing alcohol harm is not given sufficient prominence in policy discussions and agendas across national and international levels.

We agree with the suggestion in the AP that there are early indications of the global pandemic potentially magnifying these impacts: in England, the pandemic has been met with an increase in higher risk drinking.¹ And yet, the global response to the crisis also presents an opportunity. For many countries, COVID-19 has made clear our dependence on emergency health care, hospitals, social care, and police – all core services on which alcohol impacts and which must be protected from avoidable pressures. Furthermore, the disproportionate impact of COVID-19 on those with underlying conditions has illuminated the need to prioritise a preventative policy agenda, of which reducing alcohol harm must be a part.

This makes the AP’s success in progressing the GAS essential, and we commend the bold new approach that it represents. We are, however, concerned that the enormous breadth of policies and actions covered risks some of the key priorities being lost in the complexity. We believe that a concise, simpler document with clear aims and objectives linked to well-defined targets and indicators has the best chance of making a tangible difference to the implementation of the GAS.

To that end we will first provide feedback on the structure of the AP and suggest a framework that we think would improve clarity. Secondly, we will provide some suggestions on the content of the document itself.

Suggestions for structural changes

IAS welcomes the ambition of the AP and the range of actions included speaks to the breadth of the problem. We recognize however, that this document sets out an ambitious agenda with numerous targets and actions allocated to a relatively small group of stakeholders, including the WHO Secretariat. The high number of actions, that are not always clearly linked to operational objectives or goals, creates the risk

¹ Public Health England (accessed November 2020). [Wider impacts of COVID-19 on health \(WICH\) monitoring tool](#).

that the AP will become unwieldy and challenging to effectively implement and/or monitor. In order to strengthen the likelihood of the AP's success, we propose that actions are prioritized based on evidence of effectiveness to encourage efficient resource utilization. Such a prioritization exercise could follow a framework that outlines how proposed actions will help WHO meet its overarching goal of reducing alcohol harm. The incorporation of a logic model or theory of change approach could help to map how activities produce relevant outputs that lead to outcomes, which in turn contribute to broader goals.

To improve clarity, actions for each stakeholder group could be consolidated to demonstrate their relevance to WHO goals, alongside clearly defined roles and responsibilities. We also suggest that expected timelines are given for all activities listed in the AP, including timelines for monitoring and reporting on progress. In that regard, we support the Global Alcohol Policy Alliance (GAPA) proposal to require biennial reporting to the WHO Director General on progress and any challenges identified in implementing the AP at the World Health Assembly.

Suggestions

- Consider an alternative framework for mapping the actions within the document, such as a logic model;
- Prioritise and consolidate the total number of actions within the document;
- Group actions, roles and responsibilities for each stakeholder group separately; and
- Include specific and accountable timelines on all appropriate actions.

Suggestions for content

The role of industry actors

It is IAS's position that the alcohol industry has a clear conflict of interest in public health policy settings due to the health impacts of its products and reflected in its financial and legal obligations to shareholders. Therefore, alcohol industry representatives have no place in the formulation or enforcement of policies to reduce alcohol harm. The alcohol industry has a long and consistent record of obstructing or undermining effective policies. For example, the direct opposition to a SAFER policy is illustrated by the Scotch Whisky Association's protracted legal challenge to minimum unit alcohol pricing and the documented evidence that demonstrates bodies associated with the alcohol industry misrepresent the link between alcohol and cancer.²

We welcome the AP's acknowledgement of this challenge, for example the reference to the "*inherent contradiction between the interests of alcohol producers and public health*" and the recognition that the policy process at country level is "*heavily influenced by the commercial interests of alcohol producers and distributors*" (page 4). We also welcome the effort to tightly define the role of industry and support the

² The Guardian (2017). [UK supreme court rules minimum alcohol pricing is legal](#); and Petticrew, M. (2017). [How alcohol industry organisations mislead the public about alcohol and cancer](#).

statement that the AP will work to “*ensure that development, implementation and evaluation of alcohol policy measures are based on public health goals and the best available evidence and are protected from interference from commercial interests*” (page 12).

However, we believe that across the document as a whole this effort is undermined by the inclusion of the alcohol industry in every action area. Irrespective of how effectively the limited role of the alcohol industry is defined, this implies that they can contribute towards every aspect of the action plan, which is not the case. Alcohol industry representatives have misrepresented their restricted role as outlined in the Global Alcohol Strategy, which resulted in former WHO Director General Dr Margaret Chan issuing a public statement in 2014 confirming the WHO position that “the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests”.³ As aforementioned, we believe that a balance could be struck by limiting the discussion of industry activities largely to a specific section and consolidating the limited roles attributed to them. This would give scope to more precisely delineate their role, without creating the false impression that industry have an active role in all areas, and helping to protect against erroneous and damaging claims of partnership.

Suggestions

- Maintain the recognition of the influence of industry and the importance of industry being excluded from key areas such as policy development and implementation, and confine this discussion to one section of the document.

Conflicts of interest

The AP gives due recognition, as outlined above, to conflicts of interest in alcohol policy, which we firmly support. However, we are concerned that while conflicts of interest are identified as a challenge to the implementation of the GAS, concrete steps to tackle them are insufficiently prominent in the AP. For example, they are not recognised in the operational objectives of the AP nor is the WHO Secretariat tasked with monitoring or countering commercial influences (with the role falling instead exclusively to civil society).

Further, measures to manage conflicts of interest are also largely absent from key instances where they could occur, such as when the WHO Secretariat maintains a dialogue with the industry (page 12) or organizes yearly or biyearly global dialogues with the industry (page 16). The absence of such measures contrasts with WHO’s approach to nutrition policy, where a multi-sectoral approach will be accompanied by a risk assessment and management tool for safeguarding against conflicts of interest in nutrition policy development and implementation.⁴ We recommend that, as part of the AP, WHO develop principles and guidance for Member States in identifying and

³ Chan Margaret. [WHO’s response to article on doctors and the alcohol industry](#) *BMJ* 2013; 346 :f2647

⁴ WHO (2017). [Safeguarding against possible conflicts of interests in nutrition programmes: Approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level.](#)

managing conflicts of interest associated with engaging alcohol industry stakeholders in alcohol policy processes.

Suggestions

- Conflicts of interest should be explicitly referenced in the operational objectives;
- The WHO Secretariat should be given a role in monitoring and protecting against interference by alcohol economic operators;
- Where the WHO Secretariat meets with industry reference, should be made to how conflicts of interest will be transparently managed; and
- The WHO Secretariat should commit to the development of guidelines for Member States in identifying and managing conflicts of interest associated with engaging alcohol industry stakeholders.

Increase focus on SAFER

IAS supports an evidence-led approach to the development of policies to reduce alcohol-related harm, and for that reason we welcome the work of the WHO on the SAFER initiative and its prominence in the AP. However, we are concerned that the quantity of suggested actions and objectives risks the focus on SAFER being lost. We recommend that actions that relate to the SAFER framework are given priority when assessing the relevance of all actions in the AP.

We support the observation that *“alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments”* and call on the WHO Secretariat to explore further the *“calls for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control”* (page 4).

Suggestions

- The focus on evidence-based policies and SAFER should be more explicit throughout the document; and
- The WHO Secretariat should commit to explore the feasibility of an international legal instrument to accelerate action to reduce rates of alcohol harm globally

Further consideration of alcohol’s wider harms

We welcome the recognition in the AP that alcohol’s harm is not limited to individual health consequences but has a far wider societal reach. While these impacts are outlined in *‘Setting the scene’* they, by and large, do not receive much prominence in the areas for action. We support the proposed action 4.4 for Member States, to:

“Support capacity-building of health professionals, public health experts and representatives of civil society organizations, including mutual help groups and associations of affected individuals and their family members, to advocate for, implement, enforce and sustain implementation of effective measures to

reduce the harmful use of alcohol, including support of education and training programmes.”

However, this is the only action listed in the AP that refers to supporting families affected by alcohol use, and given the vision of the GAS is to “*improve health and social outcomes for individuals, families and communities*” we believe more actions to achieve this goal are required. Importantly, the impact of drinking alcohol during pregnancy and provision of support to prevent and manage foetal alcohol spectrum disorders (FASD), is largely absent from the document (referenced only on page 20 with regards to requiring further research in “*selected low- and middle-income countries*”). Greater attention is required to this issue which is a growing concern for low-, middle- and high-income countries where alcohol consumption during pregnancy remains common, yet prevention efforts and support for those affected by FASD is scarce.⁵

Suggestions

- The further inclusion of alcohol’s harms beyond the individual within the action points of the document; and
- Include reference to the impact of FASD and strategies to reduce it globally.

⁵ Popova, S. et al. (2017). [Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis](https://doi.org/10.1016/S2214-109X(17)30021-9). The Lancet Global Health doi:10.1016/S2214-109X(17)30021-9

Institute of Economic Affairs

Department/Unit: *Lifestyle economics unit*

Country/Location: United Kingdom of Great Britain and Northern Ireland

URL: www.iea.org.uk

Submission

Summary

There is a change in tone and direction in the working document that contrasts with the 2010 Global Strategy and is concerning. There are signs that alcohol consumption is replacing alcohol-related harm as the crucial measure. There is a heavy emphasis on supply side policies related to price, availability and advertising and less emphasis on harm reduction and healthcare.

Unlike the Global Strategy, the working document makes very few references to informal and illicit alcohol, and there is little acknowledgement of the dangers of excessive taxation and regulation in fostering their production. The WHO's apparent lurch towards a neo-prohibitionist approach to alcohol is regrettable and should be resisted by Member States.

Attachment(s): 1

00227_37_who-alcohol-consultation.pdf

Web based consultation on a working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol

Consultation response from Christopher Snowdon, Institute of Economic Affairs, London, UK

We have read the working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol and have the following comments and suggestions for consideration:

Summary

There is a change in tone and direction in the working document that contrasts with the 2010 Global Strategy and is concerning. There are signs that alcohol *consumption* is replacing alcohol-related *harm* as the crucial measure. There is a heavy emphasis on supply side policies related to price, availability and advertising and less emphasis on harm reduction and healthcare.

Unlike the Global Strategy, the working document makes very few references to informal and illicit alcohol, and there is little acknowledgement of the dangers of excessive taxation and regulation in fostering their production. The WHO's apparent lurch towards a neo-prohibitionist approach to alcohol is regrettable and should be resisted by Member States.

Harm-based approach versus consumption-based approach

The Global Strategy's full title is the 'Global Strategy to Reduce the *Harmful* Use of Alcohol' [my emphasis]. It is the harmful and excessive use of alcohol that is a health concern and it is unfortunate that the working document blurs the distinction between use and harmful use. It laments that 'no tangible progress was made in reducing total global alcohol consumption per capita' between 2010 and 2018 (WHO 2020: 2), as if this were the relevant metric. The proposed Global Target 1.2 is to reduce per capita alcohol consumption by a certain percentage (yet to be decided) by 2025 and 2030 (ibid. 11). There is no such target for alcohol-related deaths and disease, nor for heavy episodic drinking.

This is entirely the wrong way round. Per capita consumption is irrelevant if harm declines and there is no reason to assume that a reduction in per capita consumption will necessarily lead to a reduction in alcohol-related harm (Duffy and Snowdon 2014). Evidence for this can be found in the working document which notes on page 3 that higher income countries have higher rates of alcohol

consumption but that the 'prevalence of heavy episodic drinking is equally distributed between higher- and lower-income countries in most regions.' It also notes that the number of age-standardised alcohol-attributable deaths and disability-adjusted life years has declined in all regions except South-East Asia, despite per capita alcohol consumption rising since 2005.

The WHO should recognise that alcohol can be consumed safely and that moderate consumption has health benefits. The focus should be on alcohol-related harm, not alcohol consumption *per se*.

Illicit and informal alcohol

The WHO estimates that 25 per cent of the world's alcohol is sourced illicitly or informally (WHO 2020: 4). In countries such as Mexico and Russia, more than a third of all alcohol consumed is illicit, and the proportion exceeds 50 per cent in many African countries (IARD 2018). The illicit trade in contraband and counterfeit alcohol is a major source of criminality and tax evasion, and is hazardous to health. Unregulated 'moonshine' and surrogate alcohol causes many preventable deaths each year. In Iran, over 700 people died after drinking methanol between February and April 2020. In Punjab, India, 86 people died in July after drinking bootleg alcohol from illegal distilleries. Spates of alcohol poisonings are now commonplace, particularly in India.

The 2010 Global Strategy makes frequent references to the illicit market. It acknowledges the 'additional negative health consequences' associated with such products (WHO 2010: 17). It also acknowledges that 'restrictions on availability that are too strict may promote the development of a parallel illicit market' (ibid.: 14) and that the 'existence of a substantial illicit market for alcohol complicates policy considerations on taxation in many countries' (ibid.: 16). The working document, by contrast, makes only a brief mention of illicit alcohol, noting that it is 'associated with significant health risks and challenges for regulatory and law enforcement sectors of governments' (WHO 2020: 4).

By any measure, global consumption of contraband and counterfeit alcohol is unacceptably high. A key aim of policy should be to bring it down to the trivial levels seen in many western countries, which is to say that legal, regulated producers should increase their market share at the expense of unregulated producers. The key drivers of illicit alcohol consumption are state corruption, lack of availability (including prohibition) and lack of affordability (typically driven by taxation) (Snowdon 2012). It tends to be more common in poorer countries. Supply side measures aimed at raising prices and restricting availability can, by their nature,

only hope to deter consumption of legal, regulated alcohol which, in turn, stimulates demand for illegal substitutes.

The working document states that there is an 'inherent contradiction between the interests of alcohol producers and public health'. This is not true. Many parts of the world would benefit from having greater access to regulated alcohol products. There is insufficient acknowledgement in the working document of the unintended consequences of the WHO's 'best buys' on the black market.

Taxation

The working document and the SAFER initiative recommends tax rises on alcohol without due consideration of national contexts. Taxes on alcohol tend to be regressive and can be counter-productive. At high levels, they can lead to governments receiving less revenue as consumers switch to illicit substitutes or purchase from other jurisdictions, as happened in Estonia recently where the government was forced to reverse its alcohol tax hikes as a result of cross-border trade (Monella and Harris 2019).

A blanket injunction to 'raise prices on alcohol through excise taxes and other pricing policies' is far too crude. Differentials in price between licit and illicit products are among the key drivers of black market activity, and governments will be understandably reluctant to introduce taxes which lose them revenue. Taxes on alcohol should reflect the external costs associated with consumption and no more.

The working document raises the prospect of a global alcohol tax, saying: 'Consideration should be given to an intergovernmental commitment to a global tax on alcohol to support this effort, with the use of the money raised to be governed internationally.' It is difficult to imagine an inter-governmental organisation being better placed to spend alcohol duty revenues than Member States. Alcohol taxes are raised, in part, to meet costs to public services created by excess alcohol consumption. Healthcare, prevention, rehabilitation and other such public services can only be provided at the local or national level. An inter-governmental body would not have the reach or infrastructure to spend tax revenues on the appropriate services.

Advertising

The working document mentions alcohol advertising many times. Whereas the 2010 Global Strategy made recommendations about the content of alcohol advertising, the working document proposes a total ban. This is an extreme and unwarranted

proposal. In the vast majority of Member States, alcohol retailers and producers are legal businesses working in a competitive market. They should have the right to commercial speech.

There is very little evidence that alcohol advertising leads to an increase in alcohol consumption, let alone an increase in harmful consumption. As with most established products, the advertising of alcohol is designed to protect and grow market share for individual brands. If the aim of advertising were to increase the overall size of the market, it doesn't seem to be working very well. In the UK, for example, alcohol consumption has declined since 2004 despite the alcohol industry spending an estimated £800 million a year on advertising.

This has been shown many times in the scientific literature (Nelson 2010). For example, a study from the USA looked at sales of alcoholic beverages over 40 years and found that 'changes significantly correlated to fluctuations in demography, taxation and income levels – not advertising. Despite other macro-level studies with consistent findings, the perception that advertising increases consumption exists. The findings here indicate that there is either no relationship or a weak one between advertising and aggregate category sales. Therefore, advertising restrictions or bans with the purpose of reducing consumption may not have the desired effect' (Wilcox, Kong and Chilek 2015).

A ban on alcohol advertising would be unconstitutional in some Member States and would be illiberal and ineffective everywhere.

Activism

Action Area 2 in the working document focuses on political activism and the perceived need 'to mobilize different stakeholders for coordinated actions' (WHO 2020: 13). It is difficult to see how Member States could act on such recommendations ethically. It is not the job of governments, nor of inter-governmental agencies, to act as pressure groups or support pressure groups. It would be wrong for taxpayers' money to be used to assist third party activists or to support lobbying from one side. If the WHO has policy proposals, it should put them to Member States who can then put them to their electorate.

I note with concern that the WHO has been working closely with Movendi International, a temperance group that advocates total abstinence from alcohol.¹ Until 2019, it was known as the International Order of Good Templars. While it is

¹ https://publicspace.who.int/sites/GEM/official_relations_details.aspx?id=303

right that the WHO hears from any interest groups that wish to offer their input, it should not give preferential treatment to organisations that have strong religious or ideological objections to alcohol.

I note with concern a drift towards an extremist temperance mentality in parts of the working document. Implicit in the suggestion of launching a 'World No Alcohol Day' is the idea that zero alcohol consumption is the ideal. The similarity to World No Tobacco Day is probably no coincidence and is one of several examples of the working document conflating the risks of smoking with the risks of drinking. Elsewhere, it raises the prospect of 'a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control'. The next draft of the document should make it clear that alcohol is not tobacco and the two should not be regulated in the same way. The WHO should not become a prohibitionist organisation.

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Instituto Juan de Mariana

Country/Location: Spain

URL: www.juandemariana.org

Submission

Alcohol consumption among young people is common as a form of socialization. According to the World Health Organization (2018) over a quarter of young people between 15 and 29 years are regular drinkers, to which should be added another 11% who are beginning to consume alcohol.

It is true that the younger population drinks alcohol regularly in a smaller proportion compared to the total population (43%), but it should be borne in mind that in many regions of the world the peak is in the next stage (20-24 years), so many of the prevention actions taken at an early age could be very beneficial in the global statistics after a few years. Also, heavy drinking is a serious problem in Europe and in developed countries such as Australia, Canada, New Zealand, and the United States, with 1 in 5 adolescents aged 15-19 years regularly drinking.

The problem is that young people believe that alcohol consumption on weekends does not cause serious health problems, despite the fact that science proves that it can generate difficulties in physical, mental, and social development, while the willingness to generate alcohol dependence increases considerably. In fact, diseases such as liver cirrhosis or liver cancer have a clear causal relationship with alcohol consumption.

The main motivation is to get the psychoactive sensation, to be able to socialize better with others, especially in celebrations and parties, and mostly on weekends. In part, this is a herd or group behavior, since, in countries like Spain (Ministry of Health, 2017), practically all young people who claim to have drunk during the last 30 days have done so precisely on weekends. The intensive consumption that takes place during these days of the week has increased considerably (2 out of 5 adolescents get drunk at least once a month).

Official international statistics provided by the World Health Organization do not reflect a decrease in the proportion of young people who consume alcohol, despite the numerous and costly awareness campaigns carried out by public and private institutions, not to mention the establishment of restrictive policies. Some of the measures taken by the different regions have been in line with the global strategies to reduce alcohol consumption set by the WHO, such as increasing sales bans at certain times, limiting advertising, or implementing dissuasive taxes.

Thus, new strategies need to be addressed to achieve the goal of reducing alcohol consumption among young people, especially underage drinkers. This is especially true considering the fact that supply-side policies in some places are not having the expected results (for example, for European Union member countries, more than 80% of young people find it relatively easy to purchase alcoholic beverages (Eurocare, 2014)).

One of the strategies being tested in some countries is the application of behavioral economics. This means that through small incentives or pushes from institutions it is possible that they can make citizens change our way of acting and help us make better decisions.

This branch of science that mixes economic knowledge with psychology is relatively recent since the first relevant works were published in the 1970s. However, despite its youth, there have already been several figures and contributions which have stood out. To give an example, in the last 20 years, the Nobel Prize in Economics has been awarded at least twice to economists related to economic psychology (Daniel Kahneman and Vernon Smith in 2002, and Richard Thaler in 2017). Moreover, some countries have created offices to implement the ideas of this area of academia. In fact, the United Kingdom is the most advanced country in this regard, since in 2010 when they founded the so-called Behavioural Insights Team, informally known as the "Nudge Unit".

Some studies have put into practice the ideas of this branch with the aim of discouraging alcohol consumption among young people, especially since the decisions of individuals are based more on how they compare and classify themselves with respect to others, rather than the differences with respect to the average.

One of the most interesting works has been published by Taylor et al. (2015). The authors sampled 101 university students in the United Kingdom who were heavy drinkers. They sent four types of text messages over four weeks:

- (1) One group was sent a text message indicating how much they had drunk compared to the rest of the group, i.e., a typical message might be "you are among the top 10% of drinkers" (range comparison)
- (2) The second group was sent messages showing a comparison of their alcohol consumption with the official recommendations. (Absolute comparison)
- (3) The third group was sent a message comparing their consumption with the average of the group being tested. (average comparison).
- (4) The last group received a message with the official consumption guidelines. (absolute framework)

The results indicate that in the first group, i.e., those who received messages ranking them according to their consumption with respect to others, half of them asked for more information on the effects of alcohol consumption, and 25% requested details on specialized services for people concerned about their intake of spirits. The information requested by groups 2, 3, and 4 was much lower, at 5%, 11%, and 20%, respectively, while only 5% asked for advice about receiving more specialized care.

This highlights that it is necessary to change the methods of communication by public and private institutions. We are not suggesting that the work is done so far is ineffective, simply that it is insufficient, and perhaps new methods such as those proposed in this document need to be applied.

More specifically, it might be interesting to apply behavioral economics methods. It should be taken that the habit of drinking alcohol by young people is a social phenomenon, massively followed into consideration, so starting to apply methods such as sending messages or developing applications which classify adolescents according to their consumption within their reference group (school, municipality, province, etc.) could help them internalize the dangers of drinking this type of substance, especially among those who are most abused.

This type of measure should be accompanied by the traditional information about the dangers of excessive alcohol consumption, trying to offer real testimonies from people close to or known by young

people to increase their awareness, while also offering advice and help to those in whom these techniques have achieved the desired goal.

Attachment(s): 1

00156_11_behavioral-economics-to-reduce-alcohol-consumption-among-the-youth.pdf

Behavioral economics to reduce alcohol consumption among the youth (ENG)

Alcohol consumption among young people is common as a form of socialization. According to the World Health Organization (2018) over a quarter of young people between 15 and 29 years are regular drinkers, to which should be added another 11% who are beginning to consume alcohol.

It is true that the younger population drinks alcohol regularly in a smaller proportion compared to the total population (43%), but it should be borne in mind that in many regions of the world the peak is in the next stage (20-24 years), so many of the prevention actions taken at an early age could be very beneficial in the global statistics after a few years. Also, heavy drinking is a serious problem in Europe and in developed countries such as Australia, Canada, New Zealand, and the United States, with 1 in 5 adolescents aged 15-19 years regularly drinking.

The problem is that young people believe that alcohol consumption on weekends does not cause serious health problems, despite the fact that science proves that it can generate difficulties in physical, mental, and social development, while the willingness to generate alcohol dependence increases considerably. In fact, diseases such as liver cirrhosis or liver cancer have a clear causal relationship with alcohol consumption.

The main motivation is to get the psychoactive sensation, to be able to socialize better with others, especially in celebrations and parties, and mostly on weekends. In part, this is a herd or group behavior, since, in countries like Spain (Ministry of Health, 2017), practically all young people who claim to have drunk during the last 30 days have done so precisely on weekends. The intensive consumption that takes place during these days of the week has increased considerably (2 out of 5 adolescents get drunk at least once a month).

Official international statistics provided by the World Health Organization do not reflect a decrease in the proportion of young people who consume alcohol, despite the numerous and costly awareness campaigns carried out by public and private institutions, not to mention the establishment of restrictive policies. Some of the measures taken by the different regions have been in line with the global strategies to reduce alcohol consumption set by the WHO, such as increasing sales bans at certain times, limiting advertising, or implementing dissuasive taxes.

Thus, new strategies need to be addressed to achieve the goal of reducing alcohol consumption among young people, especially underage drinkers. This is especially true considering the fact that supply-side policies in some places are not having the expected results (for example, for European Union member countries, more than 80% of young people find it relatively easy to purchase alcoholic beverages (Eurocare, 2014)).

One of the strategies being tested in some countries is the application of behavioral economics. This means that through small incentives or pushes from institutions it is possible that they can make citizens change our way of acting and help us make better decisions.

This branch of science that mixes economic knowledge with psychology is relatively recent since the first relevant works were published in the 1970s. However, despite its youth, there have already been several figures and contributions which have stood out. To give an example, in the last 20 years, the Nobel Prize in Economics has been awarded at least twice to economists related to economic psychology (Daniel Kahneman and Vernon Smith in 2002, and Richard Thaler in 2017). Moreover, some countries have created offices to implement the ideas of this area of academia. In fact, the United Kingdom is the most advanced country in this regard, since in 2010 when they founded the so-called Behavioural Insights Team, informally known as the "Nudge Unit".

Some studies have put into practice the ideas of this branch with the aim of discouraging alcohol consumption among young people, especially since the decisions of individuals are based more on how they compare and classify themselves with respect to others, rather than the differences with respect to the average.

One of the most interesting works has been published by Taylor et al. (2015). The authors sampled 101 university students in the United Kingdom who were heavy drinkers. They sent four types of text messages over four weeks:

- (1) One group was sent a text message indicating how much they had drunk compared to the rest of the group, i.e., a typical message might be "you are among the top 10% of drinkers" (range comparison)
- (2) The second group was sent messages showing a comparison of their alcohol consumption with the official recommendations. (Absolute comparison)
- (3) The third group was sent a message comparing their consumption with the average of the group being tested. (average comparison).
- (4) The last group received a message with the official consumption guidelines. (absolute framework)

The results indicate that in the first group, i.e., those who received messages ranking them according to their consumption with respect to others, half of them asked for more information on the effects of alcohol consumption, and 25% requested details on specialized services for people concerned about their intake of spirits. The information requested by groups 2, 3, and 4 was much lower, at 5%, 11%, and 20%, respectively, while only 5% asked for advice about receiving more specialized care.

This highlights that it is necessary to change the methods of communication by public and private institutions. We are not suggesting that the work done so far is ineffective, simply that it is insufficient, and perhaps new methods such as those proposed in this document need to be applied.

More specifically, it might be interesting to apply behavioral economics methods. It should be taken that the habit of drinking alcohol by young people is a social phenomenon, massively followed into consideration, so starting to apply methods such as sending messages or developing applications which classify adolescents according to their consumption within their reference group (school, municipality, province, etc.) could help them internalize the dangers of drinking this type of substance, especially among those who are most abused.

This type of measure should be accompanied by the traditional information about the dangers of excessive alcohol consumption, trying to offer real testimonies from people close to or known by young people to increase their awareness, while also offering advice and help to those in whom these techniques have achieved the desired goal.

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Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz

Department/Unit: *Dirección de Investigaciones Epidemiológicas y Psicosociales*

Country/Location: Mexico

URL: <http://www.inprf.gob.mx/>

Submission

Después de revisar la magnífica propuesta que han elaborado, una sugerencia es la inclusión de adoptar la perspectiva de género particularmente en el plan de acción del área 5, referente a la producción de conocimiento. Si bien en la propuesta actual se hace referencia a la importancia de investigar la relación entre el consumo de alcohol y la inequidad social y de salud, este concepto parece muy general, se podría especificar algunos de los grandes ejes de la inequidad en salud que no sólo es económica, sino también de género.

El área de acción 6 es sumamente relevante, si se logra diversificar las fuentes de recursos económicos para la implementación de políticas públicas y la generación de conocimiento, se dará un paso muy importante.

Attachment(s): 0

Instituto Nacional de Vitivinicultura

Department/Unit: *Subgerencia de Estadísticas y Asuntos Técnicos Internacionales*

Country/Location: Argentina

URL: www.inv.gov.ar

Submission

Se debe priorizar la promoción de los efecto nocivos del consumo no responsable de bebida de alta tenor alcohólico

Attachment(s): 0

International Alliance for Responsible Drinking

Country/Location: United States of America

URL: www.iard.org

Submission

Executive summary

The International Alliance for Responsible Drinking (IARD) welcomes the opportunity to comment on the World Health Organisation's (WHO) working document for the development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol ("Global Strategy").

The Global Strategy remains the leading global alcohol policy instrument and we welcome the notable progress in reducing the harmful use of alcohol since its introduction. The action plan provides a valuable opportunity to build on these successes and further our collective efforts to accelerate reduction of alcohol-related harms.

If it is to do this successfully, the action plan should be consistent with the Global Strategy, the 2018 UN Political Declaration (UNPD) on non-communicable diseases, and the directions given to WHO by MS at the 146th Executive Board (EB), other EBs, and World Health Assemblies. The working document should, therefore:

1. Maintain the entire portfolio of policy options and measures embraced by the Global Strategy and propose initiatives and activities to advance its implementation
2. Focus on reducing harmful use of alcohol, and refrain from making recommendations aimed at reducing consumption per se
3. Recognize the positive contributions that economic operators can make in reducing the harmful use of alcohol
4. Fully incorporate economic operators within a whole-of-society approach at all levels (multilateral, regional, and national)

In addition, the action plan should not be used to:

- * Supersede the Global Strategy or narrow the approach taken to reducing the harmful use of alcohol
- * Modify or extend the WHO's activities to include actions outside the scope of those approved by Member States in the Global Strategy
- * Promote the SAFER initiative in a way that undermines the full menu of policy options included in the Global Strategy or minimize the Strategy's emphasis that policy should be implemented according to local and national contexts
- * Propose policy interventions that have not been endorsed by Member States through the 146th EB decision on the harmful use of alcohol

* Undermine the whole-of-society approach by isolating the role of economic operators, limiting economic operators' ability to positively and proactively engage with all stakeholders involved in a whole-of-society approach, or question the positive role that beer, wine, and spirits producers can play in efforts to reduce harmful drinking

These points are addressed in detail in our full submission, which is annexed as a PDF. Further comments are also provided on digital marketing, labeling, research funding, advocacy, and COVID-19.

We look forward to having the opportunity to comment on future iterations of the action plan, and are confident that through positive, constructive, and continuous engagement among all stakeholders, we will further progress our collective efforts to reduce the harmful use of alcohol.

Attachment(s): 1

00356_26_iard-submission-for-dec-2020-who-web-based-consultation.pdf



WHO web-based consultation on the draft action plan to implement the Global strategy to reduce the harmful use of alcohol: IARD response

Executive summary

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If it is to do this successfully, the action plan should be consistent with the [Global Strategy](#), the [2018 UN Political Declaration](#) (UNPD) on non-communicable diseases, and the directions given to WHO by MS at the 146th Executive Board (EB), other EBs, and World Health Assemblies. The working document should, therefore:

1. Maintain the entire portfolio of policy options and measures embraced by the Global Strategy and propose initiatives and activities to advance its implementation
2. Focus on reducing *harmful use* of alcohol, and refrain from making recommendations aimed at reducing consumption *per se*
3. Recognize the positive contributions that economic operators can make in reducing the harmful use of alcohol
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- Propose policy interventions that have not been endorsed by Member States through the 146th EB decision on the harmful use of alcohol
- Undermine the whole-of-society approach by isolating the role of economic operators, limiting economic operators' ability to positively and proactively engage with all stakeholders involved in a whole-of-society approach, or question the positive role that beer, wine, and spirits producers can play in efforts to reduce harmful drinking

These points are addressed in detail in our full submission, which is annexed as a PDF. Further comments are also provided on digital marketing, labeling, research funding, advocacy, and COVID-19.

We look forward to having the opportunity to comment on future iterations of the action plan, and are confident that through positive, constructive, and continuous engagement among all stakeholders, we will further progress our collective efforts to reduce the harmful use of alcohol.



WHO web-based consultation on the draft action plan to implement the Global strategy to reduce the harmful use of alcohol: IARD response

Introduction

IARD welcomes the opportunity to comment on the World Health Organization's (WHO) working document for the development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol ("Global Strategy").

The Global Strategy remains the leading global alcohol policy instrument, and there has been notable progress in reducing the harmful use of alcohol since its introduction. The action plan, therefore, provides a valuable opportunity to build on these successes and further our collective efforts to reduce harm.

We believe that the action plan should be consistent with the [Global Strategy](#), the [2018 UN Political Declaration](#) (UNPD) on non-communicable diseases, and the directions given to WHO by Member States (MS) at the 146th Executive Board (EB) in February 2020, other EBs, and World Health Assemblies. Consequently, the action plan should:

1. Maintain the entire portfolio of policy options and measures embraced by the Global Strategy and offer initiatives and activities by which it can be effectively implemented
2. Focus only on reducing *harmful use* of alcohol, and refrain from making recommendations aimed at reducing consumption *per se*
3. Recognize the positive contributions that economic operators can make in reducing the harmful use of alcohol
4. Fully incorporate economic operators within a whole-of-society approach at all levels (multilateral, regional, and national)

Comments on the working document

1. Portfolio of policy options included in the Global Strategy

The Global Strategy sets out a full portfolio of policy options that MS can draw on in their efforts to reduce the harmful use of alcohol. For the action plan to be consistent with the Global Strategy, the primacy of the full portfolio of policy options included in the Global Strategy must be maintained. By maintaining the full portfolio of policy options included in the Global Strategy, the action plan can create greater opportunity for whole-of-society solutions to be delivered that are appropriately tailored to national and cultural contexts in MS. The flexibility of the menu of options provided by the Global Strategy, and the success this has fostered, is evidenced by the positive trends seen in Member States that have deployed a diversity of approaches and policies, and engaged a variety of different sectors, to drive reductions in harmful use of alcohol. IARD's *Trend Reports* (on [HED](#), [Drink Driving](#), and [Underage Drinking](#)) include several case studies of public-private partnerships in various areas that highlight the effectiveness of this approach.

However, the working document focuses almost exclusively on promotion of the SAFER initiative and therefore risks undermining the portfolio of policy options that have been agreed upon by MS. It should be noted that the policy interventions included in SAFER may have greater relevance in some contexts than in others: another reason why their exclusive promotion is inappropriate and could slow progress in reducing

harmful drinking, rather than accelerate it. Furthermore, an exclusive focus on the SAFER initiative would require MS to implement measures previously identified as the “best buys”, despite researchers having identified a lack of evidence in low- and middle-income countries regarding the effectiveness these policies.^{1,2} It is critical that the action plan does not promote a “one size fits all” policy approach.

Given this, we do not believe that it is appropriate for the action plan to include global targets that specifically focus on implementation of the SAFER initiative (proposed global target 1.1). Instead, targets should focus on agreed outcomes, allowing MS flexibility to apply the portfolio of policies included in the Global Strategy in manner that best fits their national and cultural contexts.

2. Harmful use of alcohol

To be consistent with the Global Strategy and the UNPD, the action plan must remain focused on reducing *harmful use*. The action plan should not downplay positive trends in reducing the harmful use of alcohol that have taken place since the Global Strategy was agreed. These are clearly set out in the [Global status report on alcohol and health 2018](#).

Global estimates	2010	2016	% change
Alcohol-related death rate (per 100,000)	44.6	38.8	-13%
Alcohol-related disability-adjusted life year (DALY) rate (per 100,000)	1,968	1,759	-11%
Heavy episodic drinking (% among all)	20.5	18.2	-11%
Heavy episodic drinking (% among drinkers)	41.9	39.5	-6%
Youth (15–19-year-old) heavy episodic drinking (% among all)	15.6	13.6	-13%
Youth (15–19-year-old) heavy episodic drinking (% among drinkers)	47.5	45.7	-4%
Total consumption per capita among population aged 15+ (liters/year)	6.4	6.4	0%

Source: WHO, [Global status report on alcohol and health 2018](#)

However, the working document refers to both reducing harmful use and reducing consumption per se interchangeably, and consequently blurs the lines of the mandated objective of the Global Strategy. Specifically, the working document includes an operational objective that focuses on reducing consumption (objective 4, page 9), and suggests that alcohol consumption, rather than harmful alcohol consumption, “is associated with inherent health risks, although these risks vary significantly in magnitude and health consequences among drinkers” (page 4).

Progress in reducing the harmful use of alcohol should be viewed as a foundation upon which the action plan should build. The action plan should center on targeted activities that accelerate positive trends, address gaps where progress has not been attained, and focus on individuals and population groups who are consuming in harmful ways. For example, uneven implementation of the Global Strategy is highlighted in the working document as one of the challenges that need to be overcome. This could be addressed through peer-to-peer sharing of best practice, including in relation to public-private partnerships, without imposing a singular or one-size-fits all approach, which recognizes differences among national and cultural contexts.

¹ Siegfried, N., & Parry, C. (2019). [Do alcohol control policies work? An umbrella review and quality assessment of systematic reviews of alcohol control interventions](#) (2006-2017). PLOS ONE, 14(4), e0214865.

² Allen, L. N., Pullar, J., Wickramasinghe, K., Williams, J., Foster, C., Roberts, N., et al. (2017). [Are WHO "best buys" for non-communicable diseases effective in low-income and lower-middle-income countries? A systematic review](#). The Lancet Global Health, 5, S17.

3. Contribution of economic operators

Responsible and progressive economic operators – such as IARD members – make positive contributions to reducing the harmful use of alcohol, including through the effective use of their expertise, insights, and resources, as well as through support for co-regulatory systems. Our members are leading the sector through their actions and standard setting, and we are calling others to join us to help reduce harmful drinking.

Several new policies and partnerships have been agreed and implemented by IARD members in recent years to support and accelerate efforts to reduce the harmful use of alcohol. These include:

- The [Producer's Commitments \(2013–2017\)](#) – A set of commitments made in support of WHO and UN objectives, focused primarily on activity to be undertaken by economic operators.
- [Partnerships with leading digital platforms](#) to further raise standards in digital marketing practices, protect minors, and respect personal preferences by giving people greater control over whether they see alcohol-related marketing online.
- The January 2020 announcement of five key actions to [reduce underage drinking](#), including a commitment to place symbols or written age restrictions on alcohol beverage labels. The initiative also applies to alcohol-free extensions of alcohol brands.
- Co-regulatory partnerships to reduce harmful drinking such as the [Responsibility Deal \(2011-2015\)](#) in the U.K. and the [Prevention Agreement \(2018\) in the Netherlands](#).

In addition, the COVID-19 pandemic has further highlighted the importance of taking a whole-of-society approach to delivering positive health outcomes, and supporting lives and livelihoods. Our beer, wine, and spirits producers have made [numerous contributions](#) to communities' efforts to fight the pandemic, including supplying of 700 million bottles of hand sanitizer, supporting the hard hit hospitality industry of over \$125 million, and providing additional financial contributions totalling over \$40 million, with the majority directed towards community relief efforts, delivering healthcare, and new COVID-19 research.

To be consistent with the Global Strategy and the UNPD, the action plan should fully recognize the positive contribution of economic operators and avoid depicting economic operators as a barrier to progress.

4. Whole-of-society approach

We welcome the inclusion of economic operators in each of the action areas in the working document. This recognizes our role and contribution and is consistent with the whole-of-society approach endorsed in the Global Strategy and in the 2018 UNPD. In addition, we welcome the commitment that WHO has made to hosting dialogues with economic operators at least once a year. We place a considerable value on dialogue with WHO and believe that constructive and continuous engagement with all stakeholders is necessary to further progress efforts to reduce the harmful use of alcohol.

If the action plan is to be consistent with the Global Strategy and the UNPD, we believe that it should:

- Fully incorporate economic operators within a whole-of-society response to the harmful use of alcohol
- Recognize that a whole-of-society approach can only be successful if it is applied at all levels – multilateral, regional, and national

However, the working document treats economic operators in isolation when addressing partnership, dialogue, and coordination, which is inconsistent with a whole-of-society approach and is unnecessarily risk averse. An effective whole-of-society approach, built on regular dialogue and trust at all levels will support delivery of the objectives set out in the Global Strategy.

In addition, the working document suggests that dialogues with economic operators could take place “every second year”. We welcome the commitment WHO has made to hosting dialogues with economic operators at least once a year. We place a considerable value on dialogue with WHO, and believe that constructive and continuous engagement with all stakeholders is necessary to further progress efforts to reduce the harmful use of alcohol.

5. Progress under the Global Strategy

Last year, WHO’s Discussion Paper (the Paper) for the web-based consultation rightly noted the welcome downward trends in heavy episodic drinking (HED) “in all WHO regions, surpassing the target of a 10% relative reduction in four out of six WHO regions for the population aged 15 years and older, and in three regions (Africa, Americas, Europe) among adolescents (15–19 years of age).”

The Paper also reaffirmed the significant reductions in death and disability from harmful use of alcohol: “More than 10% reduction in age-standardized alcohol-attributable deaths is observed in the African, European and Western Pacific regions and the world, and more than 10% reduction in age-standardized alcohol-attributable DALYs – in the WHO African and European regions and in the world.”

Notable declines in underage consumption have been observed in many European and English-speaking MS, as recognized in the Paper, and WHO notes that these trends are continuing “into the next age group as the cohort ages”.

Declines in drink driving have been evident in many countries around the world with available trend data. Between 2006 and 2016, 14 European countries saw drink-drive fatalities fall by at least 50%. We agree that progress needs to be accelerated and there is no room for complacency. Much more needs to be done to continue to build on these positive trends and the action plan provides an opportunity to do this. We fully recognize that progress has not been achieved, or has not been as rapid, in some regions and that new challenges, including sizeable demographic changes, should be monitored carefully going forward.

6. Digital marketing

Digital marketing offers significant advantages over traditional marketing from a safeguard perspective. It allows marketing to be more targeted and provides a new means of eliminating exposure to marketing for key groups, such as minors. Given this, we do not believe that comprehensive restrictions or bans on marketing, including digital marketing, and e-commerce – as proposed in the working document – will support delivery of the objectives of the Global Strategy, or be effective in reducing harm.

In addition, such an approach fails to acknowledge the work that is already being undertaken to ensure that digital marketing is consistent with global efforts to reduce harmful use of alcohol. In response to the rapid nature of technological change and consumer preferences the industry has taken a leading role in ensuring that effective safeguards are developed and implemented in relation to digital marketing. A co-regulatory approach is critical to ensuring that digital marketing of alcohol is effectively managed, and consistent with efforts to reduce harmful drinking. This is why digital marketing is a key area of focus for producers who are already working in partnership with digital platforms and advertisers to raise standards in relation to digital marketing (see IARD’s [announcement](#) with Facebook (incl. Instagram), Snapchat, and YouTube). Moreover, our sector is able to deliver significant changes faster and more broadly than government regulations can.

Rather than prohibiting the use of digital marketing, the action plan should be used to highlight how the effective use of digital marketing can support the goals set out in the Global Strategy and the UNPD.

7. Industry funding of alcohol research

Producers depend on unbiased, sound research to make long-term business decisions, including on program evaluation and implementation. Economic operators welcome dialogue with WHO and academic institutions to explore mechanisms to enable credible private sector support for alcohol health and policy-related research, which addresses perceived conflicts of interest.

New models are necessary to bring desperately needed funding to alcohol health researchers, and this can only happen through trust built on dialogue across all sectors. Segregating economic operators in alcohol and trade and disabling them from engaging with researchers is counterproductive and undermines efforts to address this funding gap.

8. Advocacy

Raising awareness regarding the harmful use of alcohol is consistent with the Global Strategy, but advocacy for actions that endorse zero consumption of alcohol (as proposed in the working document) are inconsistent with the harm reduction approach embodied in the Global Strategy.

In addition, limiting advocacy to NGOs and WHO, and suggesting that it would be inappropriate for economic operators to engage, is not only inconsistent with the whole-of-society approach set out in the Global Strategy, but also risks missing out on the tremendous opportunity to harness private sector expertise and resources in promoting harm reduction messaging with their consumers. Economic operators can be powerful allies in raising awareness regarding the harmful use of alcohol.

9. Labeling

The working document proposes that the WHO Secretariat develop international standards for labeling of alcoholic beverages to “inform consumers about the content of the products and the health risks associated with their consumption.” However, it has been decided that the labeling of alcohol beverages falls within the remit of CODEX Alimentarius (“Food Code”) and is currently being deliberated by this UN body. We would caution against creating a duplicative workstream, but welcome continuing discussion with the WHO as part of our annual consultation on how the industry can set standards to improve consumer information.

10. COVID-19

The COVID-19 pandemic has demonstrated the importance of a whole-of-society approach to protecting health, and it should be used to showcase the positive outcomes that result from such an approach.

It will take time to fully understand the impact of the COVID-19 pandemic on the harmful use of alcohol. In the meantime, the action plan should:

- Not make predictions about the impact of COVID-19, including on consumption, until sufficient data – reflecting the complexity across markets and the variety of approaches taken by MS to tackle the pandemic – becomes available.
- Not include proposals related to alcohol policy that are based on the relatively short-term experience of alcohol policies introduced during the COVID-19 pandemic.

Beer, wine, and spirits producers have made [numerous contributions](#) to communities’ efforts to fight the pandemic and protect lives and livelihoods (see section 3, in this document). They will continue to support the fight against COVID-19 and the recovery of communities worldwide.

About IARD

The International Alliance for Responsible Drinking ([IARD](#)) is a not-for-profit organization dedicated to addressing harmful drinking worldwide. IARD is supported by its member companies from all sectors of the regulated alcohol industry – beer, wine, and spirits – in their common purpose of being part of the solution to reducing the harmful use of alcohol. To achieve this, we work with public sector, civil society, and private stakeholders.

IARD actively supports international goals to reduce harmful drinking, including the targets in United Nations' Sustainable Development Goal (SDG) 3.5, and the World Health Organization's (WHO) 'Noncommunicable Diseases (NCD) Global Monitoring Framework' of reducing the harmful use of alcohol by at least 10% by 2025. Our member companies also work towards a broad range of SDGs and are determined to promote sustainable development for all.

International Confederation of ATOD Research Associations

Department/Unit: *Executive Board*

Country/Location: Finland

URL: www.icara.info

Submission

ICARA proposed comments and suggestions to specific sections of the working document

ACTION AREA 1: IMPLEMENTATION OF HIGH-IMPACT STRATEGIES AND INTERVENTIONS

RE: “Civil society organizations and academia are invited to strengthen advocacy and support for implementation of high-impact policy options by creating enabling environments, promoting the SAFER initiative, strengthening global and regional networks and action groups, developing and strengthening accountability frameworks, and monitoring activities and commitments of economic operators in alcohol production and trade.”

ICARA comment: This is a constructive charge for civil society organizations and academia but there is a need, especially for academia, to be encouraged to devote more attention to policy research and evaluation.

ICARA suggestion: Incorporate a brief statement about research, e.g., Civil society organizations and academia are invited to strengthen advocacy, research and support for implementation of high-impact policy options by creating enabling environments, promoting the SAFER initiative, strengthening global and regional networks and action groups, developing and strengthening accountability frameworks, monitoring activities and commitments of economic operators in alcohol production and trade and conducting policy research and evaluation.

Action Area 4: Technical Support and Capacity building

RE: Proposed actions for Member States

ICARA comment: This section would benefit from the addition of a statement that focuses on research capacity.

ICARA suggestion: Incorporate a fifth action point that emphasizes the need to strengthen research capacity, e.g., Action 5. Develop or strengthen the capacity of public health authorities to monitor, evaluate and investigate the causes of alcohol-related harm and the impact of remedial policies by supporting university-based research and training programs in epidemiology and policy analysis.

ACTION AREA 5: KNOWLEDGE PRODUCTION AND INFORMATION SYSTEMS

ICARA Comment: ICARA fully supports the following statements in the proposed document: “Significantly more resources are required for investment in international research on alcohol policy development and implementation in low- and middle-income countries, on the reasons for uneven implementation of alcohol policy measures in different jurisdictions, with quantitative and qualitative analyses of barriers, enabling factors and the impact of different policy options, as well as in different population groups.”

ICARA suggestion: Under “Proposed actions for Member States,” add “Action 7: Provide support for training and research in the epidemiology and prevention of alcohol-related problems.”

ACTION AREA 6: RESOURCE MOBILIZATION

ICARA Comment: ICARA supports the statements made in this section. There are several areas where the statements could be clarified or otherwise improved.

RE Global target 6.2. “An increased number of countries with earmarked funding from alcohol tax revenues for reducing the harmful use of alcohol and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.”

ICARA suggestion: Change this statement to read as follows: “An increased number of countries with earmarked funding from alcohol tax revenues for reducing the harmful use of alcohol, investigating the causes, consequences and prevention of alcohol-related problems and increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.”

RE: Proposed actions for international partners and non-State actors, Action area 2, Action 3 for Nonstate Actors.

ICARA comment: This statement should be clarified because industry organizations have a major conflict of interest in the support they are increasingly providing for research even if it is “independently” conducted, and their support could bias the research agenda and serve as a form of stakeholder marketing.

ICARA suggestion: Change this statement to read: “Economic operators in alcohol production and trade are invited to allocate resources for implementation of measures that can contribute to reducing the harmful use of alcohol within their core roles, and to refrain from direct funding of public health and policy-related research to prevent any potential bias in agenda-setting emerging from the conflict of interest, and cease sponsorship of scientific research for treatment, harm reduction or prevention purposes.”

Attachment(s): 0

International Council for Advertising Self-Regulation

Country/Location: Belgium

URL: <https://icas.global>

Submission

This submission is provided by the International Council for Advertising Self-Regulation (ICAS). ICAS is a global platform which promotes responsible advertising through effective advertising self-regulation. It brings together a network of Self-Regulatory Organizations (SROs) from North & South America, Australia, Asia, Africa, and Europe as well as global associations representing the advertising industry (The World Federation of Advertisers (WFA), the International Advertising Association (IAA), the European Publishers Council (EPC), and the World Out of Home Organization (WOO)) and experts on global advertising and marketing laws, the Global Advertising Lawyers Alliance (GALA).

ICAS welcomes the opportunity to contribute to the WHO consultation on the Working Document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. Our members have worked over decades to ensure responsible advertising for alcohol beverages through effective self-regulation in many countries across the globe. One of the many strengths of the self-regulatory system is that it provides an additional layer of consumer protection that complements and, in some instances, expands on legal frameworks. Self-Regulatory Organizations keep track of key concerns about advertising and take steps to address them when needed.

We, therefore, suggest that the 2022-2030 WHO action plan to implement the Global Strategy takes into consideration:

- 1- the relentless work done by Self-Regulatory Organizations (SROs) worldwide in advancing responsible advertising, including the advertising of alcohol beverages, across all media and platforms;
- 2- the fact that the protection of children, minors and vulnerable groups is taken extremely seriously by SROs and that applicable advertising codes concerning the marketing communications for alcohol beverages and the rigorous enforcement of these codes can provide strong protections tailored to work with the individual nations' economic and legal systems. The applicable codes are sensitive to the product category and accordingly generally restrict such advertising to appropriate adult audiences and the enforcement measures are transparent and accountable;
- 3- the econometric and social benefits effective and meaningful advertising self-regulation has for consumers, businesses as well as national governments;
- 4- and, therefore, to recommend to Member States to consider effective advertising self-regulation (or co-regulation where locally applicable) when considering policy options and to build and/or strengthen a dialogue with the self-regulatory organization in their country.

We strongly believe that the goal to reduce the harmful use of alcohol can best be achieved through strong partnerships and collaboration and we thus would welcome a dialogue and co-ordination of Member States at national level with existing self-regulatory initiatives on alcohol marketing. ICAS and our members stand ready to discuss the best way we could work together to help ensure that alcohol

marketing is appropriate, and that children and minors are protected from harmful advertising and marketing practices.

In the attached submission we briefly explain the core principles of advertising self-regulation and what Self-Regulatory Organizations are doing, how it applies to marketing of alcohol beverages and finally, the benefits of the system.

Thank you for taking our submission into consideration.

Attachment(s): 1

00404_53_12122020-icas-submission-to-the-who.pdf

ICAS Submission to the WHO

WHO consultation on the working document for development of an action plan to strengthen implementation of the global strategy to reduce the harmful use of alcohol

This submission is provided by the International Council for Advertising Self-Regulation ([ICAS](#)). ICAS is a global platform which promotes responsible advertising through effective advertising self-regulation. It brings together a network of Self-Regulatory Organizations (SROs) from North & South America, Australia, Asia, Africa, and Europe¹ as well as global associations representing the advertising industry (The World Federation of Advertisers (WFA), the International Advertising Association (IAA), the European Publishers Council (EPC), and the World Out of Home Organization (WOO)) and experts on global advertising and marketing laws, the Global Advertising Lawyers Alliance (GALA).²

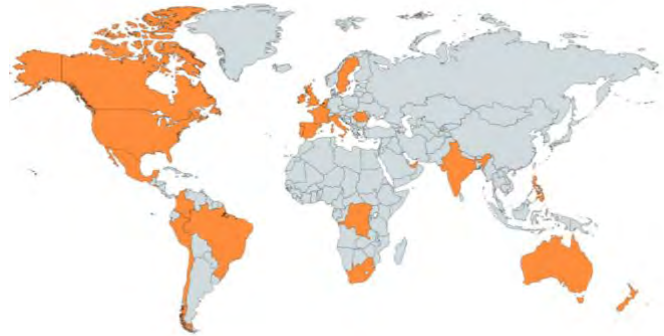


Figure 1- Map of ICAS SRO Members

ICAS welcomes the opportunity to contribute to the WHO consultation on the [Working Document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol](#). Our members have worked over decades to ensure responsible advertising for alcohol beverages through effective self-regulation in many countries across the globe. One of the many strengths of the self-regulatory system is that it provides an additional layer of consumer protection that complements and, in some instances, expands on legal frameworks. Self-Regulatory Organizations keep track of key concerns about advertising and take steps to address them when needed.

We, therefore, suggest that the 2022-2030 WHO action plan to implement the Global Strategy takes into consideration:

- 1- the relentless work done by Self-Regulatory Organizations (SROs) worldwide in advancing responsible advertising, including the advertising of alcohol beverages, across all media and platforms;
- 2- the fact that the protection of children, minors and vulnerable groups is taken extremely seriously by SROs and that applicable advertising codes concerning the marketing communications for alcohol beverages and the rigorous enforcement of these codes can provide strong protections tailored to work with the individual nations' economic and legal systems. The applicable codes are sensitive to the product category and accordingly generally restrict such advertising to appropriate adult audiences and the enforcement measures are transparent and accountable;

¹ ICAS also has in its membership the [European Advertising Standards Alliance \(EASA\)](#). Its membership is composed of 28 independent advertising self-regulatory organizations (SROs), which enforce advertising self-regulatory codes of conduct at national level, and 14 stakeholders representing the advertising ecosystem (advertisers, agencies, media and digital platforms) which are all committed to ensuring responsible advertising.

² List of ICAS members : <https://icas.global/about/members/>. An interactive map of ICAS members can be found [here](#).

- 3- the econometric and social benefits effective and meaningful advertising self-regulation has for consumers, businesses as well as national governments³;
- 4- and, therefore, to recommend to Member States to consider effective advertising self-regulation (or co-regulation⁴ where locally applicable) when considering policy options and to build and/or strengthen a dialogue with the self-regulatory organization in their country.

We strongly believe that the goal to reduce the harmful use of alcohol can best be achieved through strong partnerships and collaboration and we thus would welcome a dialogue and co-ordination of Member States at national level with existing self-regulatory initiatives on alcohol marketing. ICAS and our members stand ready to discuss the best way we could work together to help ensure that alcohol marketing is appropriate, and that children and minors are protected from harmful advertising and marketing practices.

Below, we briefly explain the core principles of advertising self-regulation and what Self-Regulatory Organizations are doing, how it applies to marketing of alcohol beverages and finally, the benefits of the system.

What is advertising self-regulation and what are SROs doing?

Advertising self-regulation is defined by a fruitful collaboration of the whole advertising industry (advertisers, agencies and the media) in developing:

- **robust advertising standards** at a national level;
- **a system for adoption, review and application of these standards;**
- **an adequately funded Self-Regulatory Organization (SRO) which then independently⁵ monitors and enforces these standards.**

The core principles for an effective advertising self-regulatory system:

High advertising standards: The existence of a self-regulatory code of standards or a set of guiding principles governing the content of ads is typically a pre-requisite for establishing a self-regulatory system. Most self-regulatory standards and programs reflect the basic principles that:

- All ads should be prepared with a due sense of social responsibility, notably in terms of being legal, decent, honest and truthful;
- All ads should conform to the principle of fair competition, as generally accepted in business, and consistent with competition laws;
- No ad should impair public confidence in advertising.

³ The benefits of advertising self-regulation are recognized by international organizations such as the Asia-Pacific Economic Cooperation (APEC), the European Union (EU), the Organization for Economic Cooperation and Development (OECD) and the United Nations Conference on Trade and Development (UNCTAD). See pages 5-6.

⁴ Co-regulation is a system of regulation combining statutory and self-regulatory elements.

⁵ Although Self-Regulatory Organizations (SROs) are primarily funded by the advertising industry, they operate independently. There are several safeguards in place to ensure that complaints on individual ads are decided independently and impartially, and decisions are usually made publicly available to ensure maximum transparency. To find more about how SROs are financed, please read our publication: https://icas.global/wp-content/uploads/2018_10_01_SRO_Funding_Overview.pdf

In most countries, advertising standards are based on the [Advertising and Marketing Communications Code](#) of the International Chamber of Commerce (the 'ICC Marketing Code'). National adjustments are however often made to take into account legal, social, cultural and economic features of the country.

Where the codes contain specific provisions, those provisions are typically agreed upon by an

independent standards-making body within the SRO, and subsequently updated on a regular basis. The main standards are also often accompanied by sectoral guidelines addressing the marketing of specific products or services (e.g., alcohol, cosmetics...) or by issue-specific guidelines (e.g., on interest-based advertising, on advertising to children, on influencer marketing, etc.), or by detailed case-specific guidance on the applicable self-regulatory standards.

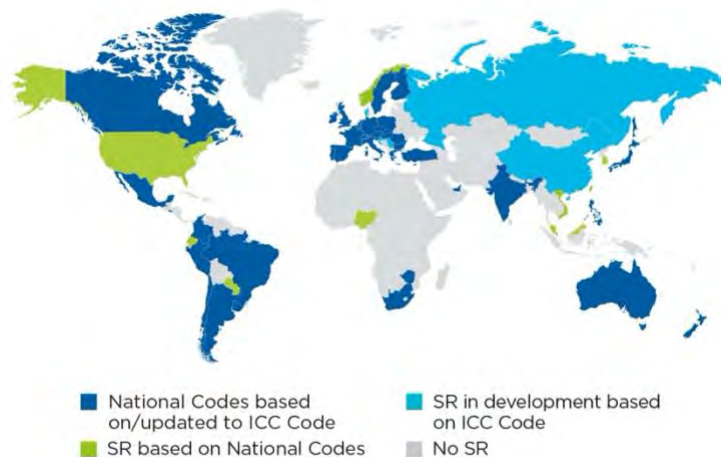


Figure 2 - Use of the ICC Marketing Code worldwide

Comprehensive coverage: The advertising standards cover all forms of marketing communications appearing in all types of media, including digital marketing techniques. The systems also cover all or a large majority of commercial actors in the advertising ecosystem. They all share a common interest in upholding high standards as loss of consumer and public trust can undermine the entire advertising industry.

Proactive compliance services, training and monitoring: To ensure a high level of awareness with the advertising standards, SROs provide a number of services to serve the needs of consumers and of the advertising industry. Educational services are especially important to make sure advertisers, agencies and the media understand their responsibilities and to ensure that there are fewer problems with ads. Such services can include online and in-person courses and trainings, certification programs, conferences, as well as partnerships with universities and other educational institutions.

Many SROs also provide copy advice, i.e., an opinion as to whether the advertisement is compliant with the local advertising standards prior to the dissemination of an advertisement. Some SROs also pre-clear advertisements. Pre-clearance, where done, requires that an ad must be assessed by the SRO as a compulsory pre-condition before it can be disseminated. Such obligation, where it exists, often covers specific media such as TV or radio, or is required for particularly sensitive sectors such as medications and medical devices, ads directed at children, or ads for financial services.⁶

Where possible, SROs also provide monitoring services in relation to specific sectors, sometimes carried out in cooperation with public authorities in co-regulation scenarios. Finally, a few SROs offer mediation services (e.g., in the telecoms sector) and specialized services to address privacy and data protection concerns around marketing practices.

⁶ In 2019, ICAS SRO members processed more than 65,000 copy advice requests. More than 68,000 advertisements were additionally pre-cleared. More information can be found in the [2019 Global Factbook of Advertising Self-Regulatory Organizations](#) available on the ICAS website.

Effective and impartial dispute resolution: In addition to services mentioned above, SROs can provide a quick, efficient and impartial complaint resolution system, which is cost-free for consumers. In most cases, the complaints are examined by an independent body within the SRO. Separate from the standards-making body, this independent body is in charge of determining whether an individual ad is in breach of the applicable self-regulatory standards and/or the applicable advertising laws. Other systems rely on qualified expert staff to make decisions.

Transparency: To ensure accountability and transparency, SROs also generally publish their decisions, or detailed summaries, online. The list of decisions (sometimes called ‘rulings’) or summaries is typically available on the SRO’s website.

Effective sanctions: Most advertisers voluntarily comply with SRO decisions by changing or withdrawing an ad or claim which has been determined as in breach of the standards. Should they refuse to do so, in some regions, SROs ask the media to refuse to publish/run or air the campaign. Ultimately, self-regulatory bodies may refer a situation where an advertiser refuses to comply with a decision or to participate in the self-regulatory process to the appropriate statutory authorities. Options available to the self-regulatory body will depend on the procedures of the self-regulatory organizations, its remit and the existing legal framework. All have proven to be effective in promoting high levels of compliance with self-regulatory decisions.

Advertising Standards and Alcohol Advertising

Ensuring responsible marketing communications for alcohol beverages has been a long-standing priority for advertising self-regulatory organizations across the globe. Especially when it comes to the protection of minors, national advertising codes and guidelines are strict and detailed. Standards usually include provisions specifying that advertising for alcoholic drinks should not be aimed at minors, should not show minors consuming alcoholic beverages, and should not be placed in media, or sponsor events, where a significant percentage of the audience is underage.

Many SROs enforce national programs and standards which reflect the principles of the [Marketing and Advertising Code of the International Chamber of Commerce](#) and its related framework, [the ICC Framework for Responsible Marketing Communications of Alcohol](#).

The industry has also developed further guidelines, principles, sector specific codes and initiatives such as the [Digital Guiding Principles](#) developed by IARD, the International Alliance for Responsible Drinking, and the [Responsible Marketing Pact](#) of the World Federation of Advertisers. The goal of these initiatives is to ensure more transparency and responsibility in the marketing of alcohol beverages, limit underage exposure to alcohol ads, to ensure alcohol ads do not appeal to minors and to ensure minors’ online experience is free from alcohol ads.

The alcohol industry commissions regular independent monitoring exercises against their sectoral codes or principles. International Self-Regulatory Organizations often play a key role in such monitoring exercises. They have monitored, for example, the compliance of beer, wine and spirits producers in their ambition to prevent minors from seeing alcohol marketing. In 2019, 14 SROs across the globe, [monitored](#) 2088 online items against the Digital Guiding Principles and the Responsible Marketing Pact, finding an increase in compliance compared to the previous year⁷.

⁷ Major international and Europe-wide monitoring exercises are co-ordinated by EASA. For more information see: <https://www.easa-alliance.org/products-services/monitoring-projects>

SROs also review complaints from consumers and from competitors and can also conduct monitoring exercises on their own initiative. For instance, the Advertising Standards Authority (ASA) in the UK monitors the exposure of children to TV ads for alcohol and gambling. Its latest report reveals a further decline in children's exposure to all TV ads in the UK, which is likely driven by a decrease in TV viewing amongst children. But it also suggests that children's exposure to TV ads for alcohol in the UK is falling at a faster rate than their exposure to all TV ads. Between 2008 and 2019 children's exposure to TV alcohol ads in the UK decreased by two thirds, from an average of 2.8 to an average of 0.9 ads per week.⁸

The Benefits of Advertising Self-Regulation and its International Recognition

The core principles of advertising self-regulation as detailed above and the work done specifically around alcohol advertising and the protection of minors, show that the self-regulatory system has numerous benefits for policy makers, consumers, marketers, and society as a whole.

For policy makers: Self-regulatory ad standards provide an additional layer of consumer protection that complements the legal framework. National advertising self-regulatory bodies help educate and thus avoid problems before they happen by providing training and copy advice. They keep track of key concerns about advertising and take steps to address them when needed. Self-regulation is also more efficient and faster than the legal process to adapt to technological and societal changes.

For marketers: It is often estimated that one-third to one-half of a company's market capitalization is represented by its brand reputation, which is why consumer trust in the brand is crucial to corporate success. Advertising self-regulation, through the promotion of responsible advertising, helps build consumer trust in brands. Maximized returns on long term investments on advertising benefit not only advertisers but also agencies and media, who will see a higher demand for creative yet responsible advertising. Advertising self-regulation also ensures an impartial and level-playing field for brands.

For consumers: Self-regulation provides an effective, inexpensive (typically cost-free), fast and efficient solution to handle consumer complaints. An efficient and meaningful self-regulatory system makes sure that advertising remains responsible and thus ensures a high level of consumer protection.

The benefits of advertising self-regulation are recognized by international governmental organizations such as the Asia-Pacific Economic Cooperation (APEC), the European Union (EU), the Organization for Economic Cooperation and Development (OECD) and the United Nations Conference on Trade and Development (UNCTAD).

- The Asia-Pacific Economic Cooperation (APEC)⁹ and the Organisation for Economic Cooperation and Development (OECD)¹⁰ have both recognized advertising self-regulation's important role and called for greater capacity building of such systems.
- The United Nations Conference on Trade and Development (UNCTAD) states in the 'Guidelines for consumer protection'¹¹ that Member States should encourage the

⁸ For more details and findings please read the ASA report: [Children's exposure to age-restricted TV ads : 2019 update](#)

⁹ [Asia Pacific Economic Cooperation \(APEC\) Joint Ministerial Statement](#), APEC, 2017

¹⁰ Industry Self Regulation : ROLE AND USE IN SUPPORTING CONSUMER INTERESTS, OECD (2015-03-01), OECD Digital Economy Papers, No. 247, OECD Publishing, Paris. <http://dx.doi.org/10.1787/5js4k1fjgkwh-en>

¹¹ UNCTAD Guidelines for Consumer Protection, 2015. https://unctad.org/system/files/official-document/ditccplpmisc2016d1_en.pdf , item 31 ; UNCTAD Manual on Consumer Protection, 2018. Page 45 https://unctad.org/system/files/official-document/ditccplp2017d1_en.pdf

formulation and implementation of codes of marketing and other business practices to ensure adequate consumer protection.

- In Europe, effective advertising self-regulation is promoted as a complement to general legislation within several policy and regulatory initiatives, such as the Audiovisual Media Services Directive (AVMSD). The revised AVMSD expressly encourages self-regulation and the use of codes of conduct in relation to alcohol marketing.¹²
- The European Union's Better Regulation package¹³ commends principles for effective self-regulation and its inclusion in the policy toolkit and regulatory impact assessment.
- In the US, the regulatory authority primarily responsible for oversight of advertising and marketing practice, the Federal Trade Commission (FTC) recognizes the role and efficacy of advertising self-regulation, and actively promotes participation by members of the advertising ecosystem. FTC guidance has spurred evolution of self-regulatory requirements, and the enforcement programs of the NAI and DAA, regarding interest-based advertising, offering a first line of compliance enforcement, reducing the burden on regulators.¹⁴

For more information, please contact



The International Council for Advertising Self-Regulation (ICAS)

c/o EASA, Rue des Deux Églises 26, 1000 Brussels, Belgium

Contact person: Sibylle Stanciu, ICAS Manager

Tel.: +32 486 89 0250

<https://icas.global>

info@icas.global

¹² Recital 29 of the [Directive \(EU\) 2018/1808 concerning the provision of audiovisual media services \(Audiovisual Media Services Directive\)](#) states: 'Similarly, Member States should be encouraged to ensure that self- and co-regulatory codes of conduct are used to effectively reduce the exposure of children and minors to audiovisual commercial communications for alcoholic beverages. Certain self- or co-regulatory systems exist at Union and national level in order to market alcoholic beverages responsibly, including in audiovisual commercial communications. Those systems should be further encouraged, in particular those aiming at ensuring that responsible drinking messages accompany audiovisual commercial communications for alcoholic beverages.'

¹³ [European Union's Better Regulation Package](#), European Commission, 2015

¹⁴ See [Letter from Federal Trade Commission to National Advertising Division](#) in re Advertising by Creekside Natural Therapeutics LLC, for Creekside Focused Mind Jur. Dietary Supplement, March 31, 2020; see also [Electronic Retailing Self-Regulation Program in re Advertising](#) by Alo LLC, d/b/a Alo Yoga, June 20, 2019

International Council of Nurses

Country/Location: Switzerland

URL: www.icn.ch

Submission

The International Council of Nurses (ICN) endorses the vision behind the Global Strategy, “improved health and social outcomes for individuals, families and communities through considerably reduced morbidity and mortality due to the harmful use of alcohol and the ensuing social consequences”. In its recently released Mental Health Position Statement, the organization recognizes the role of substance use disorders in the rising mental health Global Burden and rise in complex non-communicable diseases.

ICN encourages its member national nurses associations to lobby regional and federal agencies to strengthen technological, human and financial resources in support of substance use services especially for vulnerable populations severely impacted by harmful use of alcohol infants, youth, indigenous populations and older adults. The Mental Health position of ICN complements the aims of this SAFER initiative, and the action steps proposed in this working draft. Nursing organizations can encourage appropriate education of their leaders and constituencies to support actions and policies targeting reduction in harmful use of alcohol.

Risk and harm reduction policies are central to nursing interventions and health promotion, and specifically, those for NCDs. Actions by the nursing workforce are allied with #2 of the Global Strategy to Reduce Harmful Use of Alcohol. These actions translate to generating knowledge through nursing research and disseminating knowledge on the magnitude of harmful use of alcohol, and effectiveness and cost- effectiveness of preventive and treatment interventions.

The need to develop appropriate alcohol policies, harm reduction and alcohol focused activities has been brought into graphic relief by the COVID 19 pandemic. Indicators of accelerated rates of substance use, particularly alcohol, have been noted among health professionals, including nurses, as well as the general public. The effects of workforce strain and trauma secondary to the COVID-19 pandemic stands to compromise the mental health of nurses for years to come and early intervention, screening and evidence- based treatment is more important than ever.

The development and interpretation of mental health/substance use policy are encouraged and supported by ICN. Policies and programs directed at reducing health inequalities and advancing universal health coverage align with the goals to ICN and its members, and operations that address the high rates of harmful alcohol use in low- and middle-income countries will positively influence societal health.

Suggestions: New knowledge on the negative health and social consequences of the harmful use of alcohol and alcohol’s causal relationships with some types of cancer, liver and cardiovascular diseases, as well as its association with increased risk of infectious diseases such as tuberculosis and HIV/AIDS are key activities requiring broad dissemination. There is wide discrepancy in the knowledge levels of health professionals and health professional organizations around the world about alcohol and health with the result that essential health teaching and appropriate interventions do not happen. The nursing

workforce is essential to “increasing the health literacy and health consciousness of the general public” and nursing welcomes opportunities to strengthen prevention activities and scale-up screening and brief interventions in health services.

Attachment(s): 0

International Council on Alcohol and Addictions

Country/Location: Switzerland

URL: icaa.ch

Submission

Submission to WHO Action Plan to Strengthen Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

December 2020

The International Council on Alcohol and Addictions (ICAA) is dedicated to the prevention and reduction of the harmful use and effects of alcohol, tobacco, drugs, and addictive behaviours on individuals, families, communities, and society.

It sensitises, empowers, and educates organisations and individuals, and advocates for effective partnerships in prevention, treatment, research, and policy development in the interest of public health, personal and social wellbeing at international, regional, and national levels by collaborating with relevant bodies, organising conferences and other activities.

ICAA believes in the exchange of evidence-based knowledge and innovative approaches. It is committed to undertake this in an independent, apolitical, inclusive, democratic, and transparent manner.

ICAA therefore welcomes the WHO initiative to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol and its Action Plan to support engagement in Member States. We believe that implementation across countries has been uneven and needs to be strengthened through new resources and their efficient deployment, including through better health coverage.

- Policy approaches and interventions

Cultural differences and norms around drinking do not lend themselves to one-size-fits-all policy approaches. This was recognized in the 2010 Global Strategy. Therefore, we support the creation of an Action Plan that is flexible and not proscriptive, includes options for Member States, and allows implementation as is most appropriate and feasible in specific contexts.

Such a plan must take into consideration:

- o Available resources and technical skills at the national level
- o Degree of transferability of policy measures across countries and contexts
- o Efforts around preventive education and health promotion sensitive to local and regional perceptions of normality and likely to result in behavior change
- o The need for local tailoring and targeting compatible with culture and custom

Where health systems and resources are poor, efforts to strengthen these should be a priority.

Accessibility and availability are recognized as factors influencing consumption. Fiscal measures and restrictions on availability are an important component of the Action Plan. However, they should not be its sole focus. We believe that the best approach to reducing harmful drinking relies on a mix of regulatory measures and interventions aimed at harm reduction through educating the public and raising awareness of healthy lifestyles. Targeted interventions are essential and efforts must be made to improve their assessment and evaluation.

- Drinking patterns and measures of harmful drinking

There is wide variation in both drinking patterns and outcomes, both across countries and within them. Sustainable alcohol policies need to take this into account, as well as the key role of social determinants, including poverty, urbanization, and educational level.

Therefore, aggregate measures alone, specifically alcohol consumption per capita, are insufficient to understand alcohol-related harm and implement measures to reduce it. Data collected must also include specific indicators of harmful drinking. WHO's Global Action Plan for the Prevention and Control of Non-Communicable Diseases already lays out appropriate indicators. These include heavy episodic drinking, and alcohol-related mortality and morbidity, in addition to per capita alcohol consumption. Attention is also needed to rate of underage drinking across countries, which are an additional and important indicator. We believe that these should also be included in the Action Plan and make both efforts consistent.

- Data collection

We welcome the strengthening of technical assistance to Member States and emphasis on improved monitoring and surveillance to support the collection of data, which in many countries is poor or entirely lacking.

We encourage the development and use of common rigorous scientific methodologies that will allow comparisons of outcome measurements across countries, regions and contexts.

As the Action Plan acknowledges, significant strides have already been made towards reducing heavy episodic drinking and underage drinking across regions. Strong data collection is needed to ensure that this trend can continue.

Unrecorded alcohol comprises a significant proportion of alcohol consumed around the world and is another important area where data are scant, and improvement is needed. Unrecorded alcohol consumption and trade are directly correlated with restrictions on legal alcohol. Therefore, efforts must be made to avoid an increase in illegal production and sales and proper enforcement of existing regulation should take precedence over the enactment of new measures.

- Social context and determinants

Alcohol-related mortality and morbidity do not occur in a vacuum. They are heavily influenced by socio-cultural conditions, the environmental context, and the degree of enforcement of existing regulations and policies. Therefore, to address harmful drinking, Member States must also address health inequalities and the prevalence of conditions like obesity, mental health problems, and drug abuse.

Attention is also needed to the changing drinking patterns among women, the impact of factors like childbearing age and the number of children, as well as the evolving social and economic status of women in many societies. These can support engagement on reducing harmful drinking, but also broader issues like violence against women and domestic violence, as outlined in the ICAA resolution on women and alcohol [<http://icaa.ch/events/events.html#Women-in-Addiction-Resolution>].

ICAA would press for greater localization of initiatives targeting populations using interventions based on sound research. Effective prevention and harm reduction strategy must flow from detailed understanding of the factors contributing to alcohol availability, consumption, and associated harms in specific communities, including perceptions and cultural views.

- Stakeholder engagement

Therefore, we believe that to be successful, the Action Plan must include an equal seat at the table for all stakeholders – governments, NGOs, civil society, and the private sector. It should encourage and foster collaboration.

The Action Plan must also acknowledge the existence of diverse views and perspectives, diverging evidence on the effectiveness of individual measures in different contexts, and the contributions that each stakeholder group can make. This applies both within and outside of the core competencies each brings to the table in the common goal of reducing harmful drinking.

ICAA welcomes the emphasis on implementing the Global Strategy and is committed to encouraging and supporting its stakeholders in pursuit of a balanced and inclusive approach to achieving this goal.

Attachment(s): 0

IOGT Iceland

Country/Location: Iceland

URL: www.iogt.is

Submission

Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

IOGT Iceland is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

IOGT Iceland is an NGO working in prevention field since 1884. IOGT Iceland works with together with members, volunteers, communities, institutes and other organisations for all the Sustainable development goals. IOGT Iceland has been working with new and old questions like:

- There is no need to talk about amount (harmful use), since any amount can be harmful In so many different ways. We have more and more evidence every day about the harm regardless to the used amount of alcohol. The words has already been changed in the Sustainable Developpment Goals 3.5.2
- The role of NGO's. The working document states: „Civil society organizations and academia are invited to strengthen advocacy and support for implementation of high impact policy options by creating enabling environments, promoting the SAFER initiative, strengthening global and regional networks and action groups, developing and strengthening accountability frameworks, and monitoring activities and commitments of economic operators in alcohol production and trade.“ We find it important to draw out the importance of the civil society in spreading the news about healthy lifestyle well as monitoring the society. NGO's are watching govermental actions and policies, holding them accountable.
- We would like to see more about alcohol as a carcinogen in this working document and the final paper as it has been proven long time ago. Way to few people in the world know about alcohol causing cancer.
- We would like to see mor about FASD in this working document and the final paper as it has been proven long time ago.
- We would like to see mor about damage to the frontal brain from alcohol in this working document and the final paper as it has been proven as a alcoholharm long time ago.

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition
2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
4. Ensure greater focus on the SAFER strategies;
5. Ensure greater focus on governance and infrastructure improvements;
6. Improve resourcing as well as reporting and review of implementation; and
7. Update nomenclature in line with state-of-the-art evidence.

B. Additional point to be added to the action plan

1. Suggestion for elements of the action plan
- C. Point of criticism and request for significant change

1. Role of the alcohol industry, conflict of interest

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome – and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and

sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstinence rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this is a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world’s children. The WHO–UNICEF–Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children’s health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.

- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Operational objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

Where possible, actions and key indicators should be time-bound.

4. Ensuring greater focus on the SAFER strategies

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan to ensure that limited resources can be used to have the greatest impact in preventing and reducing alcohol harm,

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions – to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol.

We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where a focus on the implementation of the alcohol policy best buys – that has largely fallen short of necessity – is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document.

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements – learning lessons from other health areas.

Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.
7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings – like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals – like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.

9. There is no civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.

10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.

11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

Regarding the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,

2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and

3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called "Infrastructure".

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential – as tobacco control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden.

For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level.

We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through “SAFER pilot countries”.

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial – both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the ‘harmful use of alcohol’, and ‘economic operators’ greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

‘Harmful use of alcohol’ incorrectly implies that there are ‘safe levels’ of alcohol use and has been criticized by Member States and civil society alike. ‘Economic operators’ does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets

2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.

3. Framework for action

Operational objectives: 8

Priority areas for global action: 6

Global action: WHO

National action: Member States

4. Implementation: formulate the operational principles + policy coherence

5. Infrastructure and governance
 6. Monitoring and evaluation
- C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Attachment(s): 1

00500_24_020-12-13-who-gas-iogt-iceland.pdf

Submission – WHO Consultation – Working Document to develop an action plan for improving WHO GAS* implementation

IOGT Iceland is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

IOGT Iceland is an NGO working in prevention field since 1884. IOGT Iceland works together with members, volunteers, communities, institutes and other organizations for all the Sustainable development goals. IOGT Iceland has been working with new and old questions like:

- There is no need to talk about amount (harmful use), since any amount can be harmful in so many different ways. We have more and more evidence every day about the harm regardless to the used amount of alcohol. The words have already been changed in the Sustainable Development Goals 3.5.2
- The role of NGO's. The working document states: „Civil society organizations and academia are invited to strengthen advocacy and support for implementation of high impact policy options by creating enabling environments, promoting the SAFER initiative, strengthening global and regional networks and action groups, developing and strengthening accountability frameworks, and monitoring activities and commitments of economic operators in alcohol production and trade.“ We find it important to draw out the importance of the civil society in spreading the news about healthy lifestyle well as monitoring the society. NGO's are watching governmental actions and policies, holding them accountable.
- We would like to see more about alcohol as a carcinogen in this working document and the final paper as it has been proven long time ago. Way too few people in the world know about alcohol causing cancer.
- We would like to see more about FASD in this working document and the final paper as it has been proven long time ago.
- We would like to see more about damage to the frontal brain from alcohol in this working document and the final paper as it has been proven as an alcohol harm long time ago.

The work in our country for development through alcohol prevention is contingent on strong WHO support for our government and we see a big and urgent need for the World Health Organization to step up their support for alcohol policy development and implementation on global, regional and national level, as our country continues to struggle with the heavy alcohol burden. It is in this context that we make our submission.

As members, we support and endorse the detailed and comprehensive submission of Movendi International. Therefore, we focus on elements that need improvement for developing an impactful action plan that has the potential to make an impact on country level.

*WHO GAS = WHO Global Alcohol Strategy

Content of the submission overview

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition
2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions;
3. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;
4. Ensure greater focus on the SAFER strategies;
5. Ensure greater focus on governance and infrastructure improvements;
6. Improve resourcing as well as reporting and review of implementation; and
7. Update nomenclature in line with state-of-the-art evidence.

B. Additional point to be added to the action plan

1. Suggestion for elements of the action plan

C. Point of criticism and request for significant change

1. Role of the alcohol industry, conflict of interest

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

Given the lack of adequate action in implementing the three alcohol policy best buys in countries around the world in the last decade and given the rising alcohol burden, we call for bolder targets and higher ambitions.

- We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
- And we propose a bold and ambitious target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries, to reach the SDGs.

2. Strengthen the analysis of challenges and opportunities and better link to other parts of the action plan, especially the global actions

There are 15 challenges listed in the working document. This analysis is important because it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective and inadequate over the last decade.

However, not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is therefore important that the action plan reflects not just an overview of the challenges but the severity and impact of the challenges in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome – and that these challenges are reflected in the framework of action.

Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action.

The alcohol industry, together with other health harmful industries, is deploying the concept of complexity to influence how the public and policymakers understand alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis. This is not to say that it is easy to address alcohol harm or that alcohol harm is not pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that high-impact solutions are available and that it is well-understood by now how alcohol harm can be effectively prevented and reduced.

Secondly, while there might be a difference between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstinence rates are equally able to take political action to reduce their alcohol burden. The alcohol norm, alcohol myths, alcohol industry

interference, alcohol marketing practices are actually rather similar and increasingly converging. Discourse analysis across countries shows that the alcohol industry benefits from maintaining that there are vast cultural differences in alcohol norms and contexts, while the transnational alcohol giants invest heavily in achieving convergence.

Thirdly, we understand that intersectoral approaches to societal problems are not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this is a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

It is important that the action plan clearly outlines how its elements help overcome identified challenges.

We agree with the listed opportunities, seven in total.

This section is important because it provides context for global and national action to capitalize on identified opportunities. Notably, some more opportunities do exist.

In our work we experience a number of additional opportunities. We propose to include those, too:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world’s children. The WHO–UNICEF–Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children’s health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Since the ambition is that the action plan reflects the lessons learned in implementing the WHO GAS in the last decade, the analysis of the challenges and opportunities matters, and we encourage WHO to better reflect the analysis of lessons learned in other parts of the action plan.

3. Streamlining the global actions by avoiding repetition, reducing overlap and adding prioritization

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO.

We ask for the action plan to illustrate that the operational objectives and principles have a clear bearing on the global actions for WHO and Member States. Comparing the elements of the WHO GAS objectives with the new proposed operational objectives, some elements have gone missing and should be brought back. The following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

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Operational objective 8 builds on missing elements contained in WHO GAS objective 4.

We welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. They might be streamlined and prioritized.

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The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions – to underline the centrality of these five interventions in reducing mortality and morbidity from alcohol.

We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan. This should be clear in the global action areas but should also be a through line in the entire action plan, beginning with the analysis of the decade of WHO GAS implementation, where

a focus on the implementation of the alcohol policy best buys – that has largely fallen short of necessity – is currently missing.

5. Ensure greater focus on governance and infrastructure improvements

Compared to other areas of global health, the governance and infrastructure for supporting alcohol policy development and implementation worldwide is under-developed and remains inadequate. Some reasons have been indirectly addressed in the working document.

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitation of leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. Therefore, we are convinced that the action plan benefits from including a distinct section about infrastructure and governance improvements – learning lessons from other health areas.

Regarding the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
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9. There is no civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all

challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.

11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

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2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues, and

3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference.

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called "Infrastructure".

6. Improve resourcing as well as reporting and review of implementation

Regarding review and reporting, annual WHO publications about alcohol harm and or policy development are essential – as tobacco control shows, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We also want to emphasize the need to report more frequently to the WHO governing bodies, preferably through a regular stand-alone agenda item. We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to prevent and reduce alcohol harm, we recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

Prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

Regarding resourcing, already in the process of developing the action plan, governments should make stronger commitments to support WHO's work on alcohol and the Secretariat and regional offices in turn should allocate resources commensurate with the alcohol burden.

For instance, when the One Health Global Leaders Group on Antimicrobial Resistance (AMR) was launched it coincided with the announcement of \$US 13 million in donations from three European countries to a new trust fund to foster AMR action at country level.

We request a similar trust fund with initial donations from dedicated alcohol policy champion countries be set up in the lead-up to the adoption of the global action plan at the World Health Assembly in 2022, in order to facilitate immediate implementation action in the aftermath, for example through "SAFER pilot countries".

7. Update nomenclature in line with state-of-the-art evidence

We support revising the nomenclature employed for discussing the global alcohol burden and alcohol policy solutions. Consistent, clear, unambiguous and evidence-based language and messages from WHO set the standards and shape both norms and discourse. Therefore, a review of problematic concepts, terms and words is crucial – both considering scientific developments over the last ten years as well as alcohol industry attempts to exploit and hijack key concepts and terms.

For instance, by moving away from references to the ‘harmful use of alcohol’, and ‘economic operators’ greater clarity can be achieved and framings favorable to the alcohol industry can be avoided.

‘Harmful use of alcohol’ incorrectly implies that there are ‘safe levels’ of alcohol use and has been criticized by Member States and civil society alike. ‘Economic operators’ does not clearly articulate the significant financial and vested interest that alcohol corporations and their lobby groups have in increasing the sale of alcohol.

B. Additional point to be added to the action plan

As mentioned in the proposals and reflections above, we would like to suggest the following set of elements of the action plan:

1. Vision and bold targets
2. Partnership for action: include Civil Society, but highlight the primary obligation of Member States and the World Health Organization to protect people and populations from alcohol harm and to promote the human right to health and development through alcohol prevention and control; the WHO supports with normative guidance and technical assistance and the role of civil society is to ensure accountability, support, mobilization, technical expertise, community reach as well as awareness raising and advocacy.
3. Framework for action
 - Operational objectives: 8
 - Priority areas for global action: 6
 - Global action: WHO
 - National action: Member States
4. Implementation: formulate the operational principles + policy coherence
5. Infrastructure and governance
6. Monitoring and evaluation

C. Point of criticism and request for significant change

We disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action.

All stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and

consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm.

For a coherent and meaningful action plan the challenges identified should be reflected in the 6 key global action areas. Consequently, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world.

We are mindful of the way that the WHO GAS addresses the alcohol industry. Due to their fundamental conflict of interest and vast track record of interference against effective implementation of the WHO GAS the alcohol industry plays a very different role and does not pursue public health objectives regarding the response to the global alcohol burden. We therefore ask to limit attention and space given to the alcohol industry's role in the action plan.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Kópavogur 13. desember 2020

IOGT-NTO

Country/Location: Sweden

Submission

KEY COMMENTS FROM IOGT-NTO

Alcohol trade and marketing are global phenomena. The most important policy arena for alcohol is still the national level, but it is becoming increasingly clear that some issues require solutions on international or even global level.

Cross-border trade and cross-border marketing are examples of current challenges to effective alcohol policy on national level. Another example would be the lack of protection from alcohol industry interference, affecting policy outcomes in Sweden, the EU and elsewhere.

We support the emphasis in the working document about alcohol being the only psychoactive substance that is not controlled by a global, legally-binding instrument. The absence of such an instrument is probably the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).

Digital marketing and online trade of alcohol challenge traditional forms of alcohol policy regulation. We encourage the WHO to build capacity and to take on a leading role in coordinating efforts in this field and would welcome any additions to the working document in this effect.

The alcohol retail monopoly in Sweden is an essential part of our alcohol policy. The monopoly removes profit-interests from retail trade and is effective in preventing alcohol related harm through its limiting effects on availability and its strict adherence to age-limits.

We encourage WHO to draw upon the experience of retail monopolies in the Nordic countries, build capacity and include this policy option in the alcohol policy toolbox going forward.

We strongly disagree with the role assigned to the alcohol industry in the working document. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.

Attachment(s): 1

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Stockholm 2020-12-09

WHO WEB BASED CONSULTATION 16 NOVEMBER – 13 DECEMBER 2020

WORKING DOCUMENT TO DEVELOP AN ACTION PLAN FOR IMPROVING WHO GLOBAL ALCOHOL STRATEGY IMPLEMENTATION

IOGT-NTO is grateful for the opportunity to comment on the working document and appreciate the effort by WHO in conducting an ambitious consultative process. We have reviewed the document and have the following comments and suggestions for your consideration.

IOGT-NTO is a non-profit organization and popular movement. We have close to 27,000 individual members, spread over 400 local associations across the country. Our activities are based on sober foundations and aim at strengthening democracy and solidarity.

Through our activities and our advocacy work, we challenge the prevailing alcohol norm and inspire a healthy and drug-free lifestyle.

In our submission we will first outline a few key points, then we go on to give more detailed comments and proposals on the different parts of the working document.

Apart from this submission, we also support the submissions from the IOGT-NTO Movement and Movendi International.

Thank you for your consideration.

Yours sincerely,

Irma Kilim
Director of Advocacy
IOGT-NTO



KEY COMMENTS FROM IOGT-NTO

Alcohol trade and marketing are global phenomena. The most important policy arena for alcohol is still the national level, but it is becoming increasingly clear that some issues require solutions on international or even global level.

Cross-border trade and cross-border marketing are examples of current challenges to effective alcohol policy on national level. Another example would be the lack of protection from alcohol industry interference, affecting policy outcomes in Sweden, the EU and elsewhere.

We support the emphasis in the working document about alcohol being the only psychoactive substance that is not controlled by a global, legally-binding instrument. The absence of such an instrument is probably the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).

Digital marketing and online trade of alcohol challenge traditional forms of alcohol policy regulation. We encourage the WHO to build capacity and to take on a leading role in coordinating efforts in this field and would welcome any additions to the working document in this effect.

The alcohol retail monopoly in Sweden is an essential part of our alcohol policy. The monopoly removes profit-interests from retail trade and is effective in preventing alcohol related harm through its limiting effects on availability and its strict adherence to age-limits.

We encourage WHO to draw upon the experience of retail monopolies in the Nordic countries, build capacity and include this policy option in the alcohol policy toolbox going forward.

We strongly disagree with the role assigned to the alcohol industry in the working document. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.



Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.



DETAILED COMMENTS ON THE WORKING DOCUMENT

In general, we welcome and support large parts of the working document as elements of the future action plan.

REGARDING SETTING THE SCENE

We support the focus on strengthening global action, building on the mandate that Member States have given WHO in 2010 and that Member States have renewed with the WHO governing body decisions in 2019 and 2020.

Concretely, we welcome and support the effort to define clear targets and indicators.

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan. We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan (see below).

We welcome and support the analysis of and emphasis on the potential of mainstreaming alcohol policy into other relevant policy sectors and to promote cross-sectorial work to advance alcohol policy development.

Fourthly, we welcome and support the emphasis on alcohol's role across the GPW13's triple billion target. This shows what the potential of this new alcohol action plan could be: to strengthen the mandate and case for global action on the entirety of alcohol harm – in this way unlocking the full potential of alcohol policy solutions.

The working document also contains some “new” action proposals that have been discussed in previous consultations and we welcome and support their inclusion in the action plan:

- The importance of an awareness day/ week,
- The need to revise and update the nomenclature – as has been done by the UN Statistical Commission recently with regard to indicator SDG 3.5.2,
- The issue of alcohol and trade,
- The clearly spelled out link between alcohol harm and health system burden, as well as alcohol policy potential to strengthen health system capacity, and
- The emphasis on technical capacity-building.

PROPOSING A BOLD OVERARCHING TARGET

While we welcome and support the global action area targets and the indicators listed in Annex I, we miss one overarching target that underpins the goal to “considerably



reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries.

PLACING SAFER FRONT AND CENTER

The setting the scene section can be improved by placing the SAFER alcohol policy blueprint front and center. The case for action and the return on investment should be made clear from the outset: Implementation of the three best buys would result in a return on investment of \$9 for every \$1 invested. Already in 2010, the WHO Global Health Report outlined that:

“Raising taxes on alcohol to 40% of the retail price could have an even bigger impact [than a 50% increase in tobacco taxation]. Estimates for 12 low-income countries show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries “

This locates the alcohol action immediately within wider efforts to achieve universal health coverage and to reach the SDGs.

REGARDING THE WHO GAS IMPLEMENTATION

We support the analysis of the last ten years of WHO GAS implementation around the world.

While we do not disagree with the presentation of the evidence, we ask for stronger conclusions and clearer messages regarding the evaluation of the decade of WHO GAS implementation in this section.

WHO GAS implementation over the last ten years has been ineffective, inadequate and outdated. Some of the evidence should be presented to set the scene for the action plan.

- Alcohol availability regulation remains inadequate, according to findings from the WHO Global Alcohol Status 2018, to compound the situation, alcohol is actually becoming more widely and easily available. The number of licenses to produce, distribute and sell alcohol – a marker for increased rather than decreased availability – is increasing in much of the world, particularly in lower-income countries.



- Levels of treatment coverage vary substantially across countries but are inadequate across the world. Only 14% of reporting countries indicated high treatment coverage, and 28% of reporting countries indicated very limited or close to zero treatment coverage.
- Alcohol marketing regulations remain inadequate, too. Digital alcohol marketing restrictions are far behind technological innovation in the alcohol industry. 28% of countries had no regulations on any media type in 2016, most of them being located in the African or Americas regions.
- While 95% of all reporting countries implement alcohol excise taxes, fewer than half use the other price strategies highlighted in the WHO GAS – such as adjusting taxes to keep up with inflation and income levels, imposing minimum pricing policies, or banning below-cost selling or volume discounts. This shows that alcohol pricing policies remain inadequate. For example, a 2017 only 59% of responding countries had implemented a tax increase on alcoholic beverages since the adoption of the WHO GAS. Only a third of countries adjust those taxes regularly for inflation, and eight countries (five of them in the WHO European Region) reported increasing their subsidies for alcohol production.

It is important that this analysis is added to the chapter about WHO GAS implementation. It is an understatement to conclude that implementation has been “uneven”. The evidence shows that the majority of countries falls short of adequately responding to the alcohol burden with the most cost-effective and impactful alcohol policy solutions.

PROTECTING CHILDREN, YOUTH AND ADULTS WHO DON'T USE ALCOHOL

We welcome and support the discussion of the alcohol abstaining population in the world. Protecting children, youth and adults from pressures to start consuming alcohol and in their non-consuming behaviour is a guiding principle of the WHO GAS.

REGARDING WHO GAS IMPLEMENTATION CHALLENGES

We welcome and support the analysis of the challenges that WHO GAS implementation was faced with over the last decade. We note that WHO examines 15 challenges.

The reason why this section is so important is that it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective, inadequate and outdated.

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and



3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis.

Secondly, while there might be differences between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention are equally able to take political action to reduce their alcohol burden. Ireland, Russia, Uganda and Vietnam – to name a few – are very different countries but they’ve all found ways to make alcohol harm a public health priority.

Thirdly, we understand that intersectoral approaches to societal problems is not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

A MORE SYSTEMATIC ORDER OF IMPLEMENTATION CHALLENGES

Not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is important that the action plan reflects not just an overview of the challenges but the severity and impact in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome. Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power



3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

PROTECTION AGAINST ALCOHOL INDUSTRY INTERFERENCE

The discussion about the need for a global binding instrument for alcohol is at least as old as the discussion about the WHO GAS. Alcohol remains the only psychoactive substance that is not under any binding international control regime, despite its massive global burden. Therefore, protections against alcohol industry interference are missing and pose the biggest challenge to WHO GAS implementation.

The alcohol industry deploys its political, market and purchase power to interfere in public health policymaking in order to delay, derail and destroy alcohol policy-making efforts. They also leverage aggressive marketing spending, for example in the digital world – as the coronavirus crisis has brought into sharp focus, and they deploy corporate social responsibility schemes to white-wash their image, cultivate relationships and avoid statutory public health policies.

In this way, the alcohol industry contributes to and exploits and lack of political leadership and in turn policy coherence. When there is leadership, usually countries are capable of prioritizing the human right to health; but when there is unmitigated alcohol industry capture of policy-making processes short-term private interests trump the public interest. In this way, policy coherence is a function of political leadership and effective infrastructure, which are heavily influenced by the alcohol industry.

We urge for such a description to be added to the next document. Ten years of evidence from attempts to implement the WHO GAS have contributed compelling evidence.

REGARDING WHO GAS IMPLEMENTATION OPPORTUNITIES

We welcome and support the analysis of the opportunities for preventing and reducing alcohol harm; but the section should be better framed as opportunities to accelerate action on WHO GAS implementation (as are the challenges) – as called for by Member States.

We note that WHO examines 7 opportunities:

1. Youth alcohol use declining
2. Growing recognition of alcohol harms
3. Increasing health literacy
4. Social media as tool to advance awareness and literacy



5. Mainstreaming alcohol policy - alcohol and inequality, alcohol and underdevelopment
6. Return on investment data
7. Understanding of alcohol's health system burden

We agree with all these elements outlining opportunities. The reason why this section is so important is that it provides context for global and national action to capitalize on these opportunities.

PROPOSING TO ADD MORE OPPORTUNITIES

In our work we experience a number of additional opportunities. We propose to include:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world's children. The WHO-UNICEF-Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children's health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

REGARDING SCOPE OF THE ACTION PLAN



We welcome and support the scope of the action plan to comprise concrete action and significant improvements to the global governance of alcohol policy development.

Importantly, we welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

We support and welcome the actions suggested for Member States and the WHO. Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. But we support the ambition, quantity and quality of the actions outlined because it signifies Member States' obligation to ensure their citizens are protected from alcohol harm. The proposed actions also illustrate that it is WHO's responsibility to live up to the strong mandate it has received in 2010 and on different occasions since then.

ALL STAKEHOLDERS ARE NOT EQUAL

In this context, we must highlight that all stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm. There is a fundamental conflict of interest on part of the alcohol industry.

Clearly, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world (see above). Therefore, we make concrete suggestions for how the role of different stakeholders can be better reflected in the action plan.

REGARDING GOAL OF THE ACTION PLAN

We welcome and support the reiteration of the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We suggest including the health, social, economic and sustainable development consequences of alcohol but we fully endorse this overarching goal.

The recently published Global Burden of Disease study for 2019 showed that the contribution of alcohol to the global disease burden has been increasing year by year from 2.6% of DALYs in 1990 to 3.7% of DALYs in 2019. In high income countries alcohol use is the second fastest growing risk factor and in LMICs it is the fourth fastest rising risk factor. This evidence illustrates the importance of the action plan's overarching goal.



WHAT WE WANT TO IMPROVE

We welcome and support the focus on the regional and Secretariat levels towards achieving the overall goal. This paragraph might serve its purpose better under the headline “implementation” rather than under “goal of the action plan”. There needs to be a section/ chapter dealing with the vision, mission and targets of the action plan. But goals and implementation could be kept separate for purpose of clarity.

Commenting on the formulation of the goal: Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences of alcohol in the description of the goal.

REGARDING PROPOSED OPERATIONAL OBJECTIVES

We welcome and strongly support the action-oriented nature of the working document’s outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

We emphasize the short note that the operational objectives reflect the lessons learned in implementing the WHO GAS in the last decade. This is an essential quality standard of the action plan. That is why the analysis of the challenges and opportunities matters and we encourage WHO to better reflect the analysis of lessons learned in the operational objectives.

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions.

In support of the operational objectives, we propose a logical model, and we propose adding two more operational objectives that have gone missing from the WHO GAS’ objectives.

WHAT WE WANT TO ADD

We propose to add two more operational objectives. Our analysis of the working document and the WHO GAS has shown that some elements of the original objectives went missing. While we support the operational objectives as suggested in the working document, we are convinced that the following elements should also be included in the action plan’s operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and



- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Objective 8 builds on missing elements contained in WHO GAS objective 4.

PROPOSED OPERATIONAL PRINCIPLES

We welcome and support the operational principles. We believe they add value in support of the overarching guiding principles of the WHO GAS. We believe this section is important and should be expanded, for examples as in WHO Global Action Plan for Physical Activity (GAPPA).

Therefore, we propose at this stage to add the following operational principles:

- Prevention first
- Proportional universality
- Policy coherence
- Alcohol in all policies – mainstreaming approach
- Whole-of-government approach
- Engagement and empowerment of policy-makers, people, families, and communities (in a slight adjustment to the principle already on the list, last bullet point)

REGARDING PROPOSED KEY AREAS FOR GLOBAL ACTION

Broadly, we welcome and support the set of 6 key areas for global action, including the quantity and quality of the actions detailed. Some elements can be improved, some elements are missing, and some elements should be reworked while some others should be removed – as outlined in Movendi International’s submission, which we endorse.

We propose to reframe and rework the key areas for global action as “framework for action”, as for example the WHO Global Action Plan for Physical Activity (GAPPA) does. This allows to streamline the actions and create greater coherence across the action areas.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global



targets – the Member States and WHO. Therefore, we propose to include civil society and international partner action in a separate section and to focus Member States and WHO action in the “Framework for action”.

In our view, key area 1 for global action is the core of the action plan, with key areas 2 to 5 having supportive function, and with area 6 underpinning all other actions but in turn benefitting from success in area 1.

Therefore, we outlined above the importance of the SAFER alcohol policy blueprint receiving special focus in the action plan. To that end, the area one targets should be grouped in terms of alcohol consumption targets and alcohol policy developments targets, with an overall target and targets that correspond to the SAFER measures, similarly to our addition to the setting the scene section above.

Global action on reporting about alcohol consumption, related harm and policy development should reflect the magnitude and urgency of addressing the alcohol burden. In tobacco control, a global report is launched every year. For alcohol prevention and control that should be the ambition, too.

ROLE OF THE ALCOHOL INDUSTRY

We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. The working document remains incoherent, as is the WHO GAS.

It is critical that the action plan overcomes this incoherence within the frames of the mandate given by Member States through the WHO GAS but in line with a decade of evidence about the alcohol industry’s role in delaying, derailing and destroying attempts to implement the WHO GAS.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

REGARDING IMPROVEMENTS TO THE GLOBAL GOVERNANCE AND INFRASTRUCTURE FOR ALCOHOL POLICY DEVELOPMENT

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitating leadership and commitment and for advancing advocacy and fund-raising efforts.



Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. The reasons are clear and have indirectly addressed in the working document. Therefore, we are convinced that the action plan benefits from including a section about infrastructure and governance improvements – applying lessons learned from other health areas.

ON THE LEVEL OF GLOBAL ACTION:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.
5. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.
7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings – like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals – like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.



ON THE LEVEL OF NATIONAL ACTION:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues,
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference,

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called "Infrastructure".

IOGT-NTO Movement

Country/Location: Sweden

URL: <http://www.iogtntororelsen.se>

Submission

Key comments from the IOGT-NTO Movement:

1. We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.
2. We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.
3. We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand alcohol issues. We further propose to remove two other points in the list of challenges (see detailed description below).
4. The absence of a global, legally binding instrument, leading – among other things – to a lack of protection from alcohol industry interference, is the most important challenge when it comes to implementing the WHO GAS (Global Alcohol Strategy).
5. Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences in the formulation of the goal.
6. It is important that the SAFER alcohol policy blueprint receives special focus in the action plan.
7. We propose a set of concrete improvements to the global governance and infrastructure for alcohol policy development because our analysis showed that inadequate infrastructure has impeded accelerated action on the global alcohol burden. (See below).

Attachment(s): 1

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IOGT·NTO·MOVEMENT

Stockholm 2020-12-04

Submission from IOGT-NTO Movement Sweden

WHO Web based consultation 16 November – 13 December 2020

Working Document to develop an action plan for improving WHO global alcohol strategy implementation

The IOGT-NTO Movement is grateful for the opportunity to comment on the working document and appreciate the effort by WHO in conducting an ambitious consultative process. We have reviewed the document and have the following comments and suggestions for your consideration.

The IOGT-NTO Movement is based in Sweden, working to prevent harm from alcohol in East Africa, South East Asia, Sri Lanka and the Balkans. We work with policy advocacy and alcohol prevention projects together with local partner organisations in our program countries.

In our submission we will first outline a few key points, then we go on to give more detailed comments and proposals on the different parts of the working document.

Apart from this submission, we also support the submissions from Movendi International and Alcohol Policy Futures.

Thank you for your consideration.

Yours sincerely,



Pierre Andersson
Policy Advisor

IOGT-NTO Movement

IOGT·NTO·MOVEMENT

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IOGT·NTO·MOVEMENT

Detailed comments on the working document

In general, we welcome and support large parts of the working document as elements of the future action plan.

Regarding Setting the scene

We support the focus on strengthening global action, building on the mandate that Member States have given WHO in 2010 and that Member States have renewed with the WHO governing body decisions in 2019 and 2020.

Concretely, we welcome and support the effort to define clear targets and indicators.

The alcohol policy best buy solutions and the SAFER alcohol policy blueprint should be the core element of the action plan. We support the focus on the most cost-effective alcohol policy solutions and suggest expanding their place in the action plan (see below).

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Fourthly, we welcome and support the emphasis on alcohol's role across the GPW13's triple billion target. This shows what the potential of this new alcohol action plan could be: to strengthen the mandate and case for global action on the entirety of alcohol harm – in this way unlocking the full potential of alcohol policy solutions.

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- The importance of an awareness day/ week,
- The need to revise and update the nomenclature – as has been done by the UN Statistical Commission recently with regard to indicator SDG 3.5.2,
- The issue of alcohol and trade,
- The clearly spelled out link between alcohol harm and health system burden, as well as alcohol policy potential to strengthen health system capacity, and
- The emphasis on technical capacity-building.

Proposing a bold overarching target

While we welcome and support the global action area targets and the indicators listed in Annex I, we miss one overarching target that underpins the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

IOGT·NTO·MOVEMENT

We propose bold, ambitious overall targets of a 30% reduction of per capita alcohol consumption until 2030 and a target to maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.

Both targets have clear public health and sustainable development implications and underline the urgency to turn the tide on the alcohol burden. Countries have shown that alcohol policy development is effective in putting them on track towards the 10% APC reduction target of the NCDs Global Action Plan, but it is also clear that bigger ambitions are necessary, especially for high-burden countries.

Placing SAFER front and center

The setting the scene section can be improved by placing the SAFER alcohol policy blueprint front and center. The case for action and the return on investment should be made clear from the outset: Implementation of the three best buys would result in a return on investment of \$9 for every \$1 invested. Already in 2010, the WHO Global Health Report outlined that:

“Raising taxes on alcohol to 40% of the retail price could have an even bigger impact [than a 50% increase in tobacco taxation]. Estimates for 12 low-income countries show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries “

This locates the alcohol action immediately within wider efforts to achieve universal health coverage and to reach the SDGs.

Regarding the WHO GAS implementation

We support the analysis of the last ten years of WHO GAS implementation around the world.

While we do not disagree with the presentation of the evidence, we ask for stronger conclusions and clearer messages regarding the evaluation of the decade of WHO GAS implementation in this section.

WHO GAS implementation over the last ten years has been ineffective, inadequate and outdated. Some of the evidence should be presented to set the scene for the action plan.

- Alcohol availability regulation remains inadequate, according to findings from the WHO Global Alcohol Status 2018, to compound the situation, alcohol is actually becoming more widely and easily available. The number of licenses to produce, distribute and sell alcohol – a marker for increased rather than decreased availability – is increasing in much of the world, particularly in lower-income countries.
- Levels of treatment coverage vary substantially across countries but are inadequate across the world. Only 14% of reporting countries indicated high treatment coverage, and 28% of reporting countries indicated very limited or close to zero treatment coverage.

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- Alcohol marketing regulations remain inadequate, too. Digital alcohol marketing restrictions are far behind technological innovation in the alcohol industry. 28% of countries had no regulations on any media type in 2016, most of them being located in the African or Americas regions.
- While 95% of all reporting countries implement alcohol excise taxes, fewer than half use the other price strategies highlighted in the WHO GAS – such as adjusting taxes to keep up with inflation and income levels, imposing minimum pricing policies, or banning below-cost selling or volume discounts. This shows that alcohol pricing policies remain inadequate. For example, in 2017 only 59% of responding countries had implemented a tax increase on alcoholic beverages since the adoption of the WHO GAS. Only a third of countries adjust those taxes regularly for inflation, and eight countries (five of them in the WHO European Region) reported increasing their subsidies for alcohol production.

It is important that this analysis is added to the chapter about WHO GAS implementation. It is an understatement to conclude that implementation has been “uneven”. The evidence shows that the majority of countries falls short of adequately responding to the alcohol burden with the most cost-effective and impactful alcohol policy solutions.

Protecting children, youth and adults who don't use alcohol

We welcome and support the discussion of the alcohol abstaining population in the world. Protecting children, youth and adults from pressures to start consuming alcohol and in their non-consuming behaviour is a guiding principle of the WHO GAS.

Regarding WHO GAS implementation challenges

We welcome and support the analysis of the challenges that WHO GAS implementation was faced with over the last decade. We note that WHO examines 15 challenges.

The reason why this section is so important is that it outlines the context of the action plan and provides answers to why WHO GAS implementation has been ineffective, inadequate and outdated.

We propose to remove three items from the description of the challenges for WHO GAS implementation.

1. Complexity of the problem,
2. Differences in cultural norms, contexts, and
3. Intersectoral nature of cost-effective solutions.

We caution against the description of alcohol harm as “complex” problem because it plays into alcohol industry framing, thereby undermining the case for action. The alcohol industry, together with other health harmful industries, is deploying the concept of complexity widely to influence how the public and policymakers understand

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alcohol (health) issues. “Complexity” arguments are frequently used in response to policy announcements and in response to new scientific evidence, according to independent scientific analysis.

Secondly, while there might be differences between countries in the concrete composition of the alcohol market and in the regulatory framework, it is outdated to address cultural differences as a challenge to WHO GAS implementation. Countries with strong, entrenched alcohol norms, with different levels of alcohol consumption and population-level alcohol abstention are equally able to take political action to reduce their alcohol burden. Ireland, Russia, Uganda and Vietnam – to name a few – are very different countries but they’ve all found ways to make alcohol harm a public health priority.

Thirdly, we understand that intersectoral approaches to societal problems is not easy: it requires institutional mechanisms, collective learning, joint efforts and interest and commitment of individuals to change “the old” way of doing; but we do not agree that this a challenge for the implementation of the WHO GAS. If anything, it is an opportunity. The benefits of multisectoral approaches to alcohol harm are substantial. Therefore, we believe that the focus should be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

A more systematic order of implementation challenges

Not all challenges are of the same significance and severity. They should be more systematically addressed. Arguably, alcohol industry interference is a formidable challenge that foments and exacerbates other challenges, such as lack of recognition of harm, scarce technical capacity or scarce human and funding resources.

It is important that the action plan reflects not just an overview of the challenges but the severity and impact in order to address the root problems that alcohol policy-making initiatives encounter and have to overcome. Compared with the opportunities, the quality and quantity of challenges to WHO GAS implementation are substantial and it is important that the action plan clearly outlines how its elements help overcome identified challenges.

A meaningful order of challenges could be:

1. Absence of legally binding instrument
2. Influence of Big Alcohol: interference and market power
3. Alcohol marketing, including digital, satellite and CSR
4. Lack of political will and leadership at highest levels
5. Policy incoherence

Protection against alcohol industry interference

The discussion about the need for a global binding instrument for alcohol is at least as old as the discussion about the WHO GAS. Alcohol remains the only psychoactive

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substance that is not under any binding international control regime, despite its massive global burden. Therefore, protections against alcohol industry interference are missing and pose the biggest challenge to WHO GAS implementation.

The alcohol industry deploys its political, market and purchase power to interfere in public health policymaking in order to delay, derail and destroy alcohol policy-making efforts. They also leverage aggressive marketing spending, for example in the digital world – as the coronavirus crisis has brought into sharp focus, and they deploy corporate social responsibility schemes to white-wash their image, cultivate relationships and avoid statutory public health policies.

In this way, the alcohol industry contributes to and exploits and lack of political leadership and in turn policy coherence. When there is leadership, usually countries are capable of prioritizing the human right to health; but when there is unmitigated alcohol industry capture of policy-making processes short-term private interests trump the public interest. In this way, policy coherence is a function of political leadership and effective infrastructure, which are heavily influenced by the alcohol industry.

We urge for such a description to be added to the next document. Ten years of evidence from attempts to implement the WHO GAS have contributed compelling evidence.

Regarding WHO GAS implementation opportunities

We welcome and support the analysis of the opportunities for preventing and reducing alcohol harm; but the section should be better framed as opportunities to accelerate action on WHO GAS implementation (as are the challenges) – as called for by Member States.

We note that WHO examines 7 opportunities:

1. Youth alcohol use declining
2. Growing recognition of alcohol harms
3. Increasing health literacy
4. Social media as tool to advance awareness and literacy
5. Mainstreaming alcohol policy - alcohol and inequality, alcohol and underdevelopment
6. Return on investment data
7. Understanding of alcohol's health system burden

We agree with all these elements outlining opportunities. The reason why this section is so important is that it provides context for global and national action to capitalize on these opportunities.

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Proposing to add more opportunities

In our work we experience a number of additional opportunities. We propose to include:

- The need for financing development in general and sustainable, resilient health systems in particular is an opportunity to advance the implementation of the WHO GAS because of the triple-win nature of alcohol policy solutions. This point links to point 6, above.
- Along with rising health literacy, there is also increasing literacy about corporate abuse in general. This is an opportunity for advancing the implementation of the WHO GAS if consistent messages about the alcohol industry accompany public policy-making efforts.
- A third opportunity is the recent WHO-UNICEF-Lancet Commission: The WHO together with UNICEF and The Lancet have issued a new Commission on the future for the world's children. The WHO–UNICEF–Lancet Commission is set to lay the foundations for a new global movement for child health that addresses two major crises adversely affecting children's health, well-being and development – one of those being counter action against “predatory corporate behavior”, including alcohol industry practices.
- A fourth opportunity is the new infrastructure, including national, regional and global processes on a yearly basis, to implement the SDGs and to assess progress; since alcohol is included in the Agenda 2030, this provides important opportunities for awareness raising, facilitating partnerships and multisectoral approaches as well as momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked by Member States to develop to address cross-border alcohol marketing issues; this is an important opportunity to facilitate better coordinated international responses to alcohol harm and related alcohol industry activities.

Regarding Scope of the action plan

We welcome and support the scope of the action plan to comprise concrete action and significant improvements to the global governance of alcohol policy development.

Importantly, we welcome and support the set of specific actions and measures to be implemented at global level, building on the WHO GAS provisions.

We support and welcome the actions suggested for Member States and the WHO. Some of them might be repetitive; some of them might rather be located in a different place of the action plan; some might be removed and some of them might be merged; some of them might be summarized more effectively. But we support the ambition, quantity and quality of the actions outlined because it signifies Member States' obligation to

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ensure their citizens are protected from alcohol harm. The proposed actions also illustrate that it is WHO's responsibility to live up to the strong mandate it has received in 2010 and on different occasions since then.

All stakeholders are not equal

In this context, we must highlight that all stakeholders in WHO GAS implementation are not equal. The term Non-State Actors should not obscure that the alcohol industry pursues private profit interests in increasing alcohol sales and consumption while civil society promotes the public interest in protecting people, communities and societies from alcohol harm. There is a fundamental conflict of interest on part of the alcohol industry.

Clearly, the alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The alcohol industry is the single biggest obstacle to WHO GAS implementation around the world (see above). Therefore, we make concrete suggestions for how the role of different stakeholders can be better reflected in the action plan.

Regarding Goal of the action plan

We welcome and support the reiteration of the goal to “considerably reduce morbidity and mortality due to alcohol use – over and above general morbidity and mortality trends – as well as associated social consequences.”

We suggest including the health, social, economic and sustainable development consequences of alcohol but we fully endorse this overarching goal.

The recently published Global Burden of Disease study for 2019 showed that the contribution of alcohol to the global disease burden has been increasing year by year from 2.6% of DALYs in 1990 to 3.7% of DALYs in 2019. In high income countries alcohol use is the second fastest growing risk factor and in LMICs it is the fourth fastest rising risk factor. This evidence illustrates the importance of the action plan's overarching goal.

What we want to improve

We welcome and support the focus on the regional and Secretariat levels towards achieving the overall goal. This paragraph might serve its purpose better under the headline “implementation” rather than under “goal of the action plan”. There needs to be a section/ chapter dealing with the vision, mission and targets of the action plan. But goals and implementation could be kept separate for purpose of clarity.

Commenting on the formulation of the goal: Associated to alcohol use are not “only” the health and social harms, but also economic and sustainable development harms. We suggest including the health, social, economic and sustainable development consequences of alcohol in the description of the goal.

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Regarding Proposed operational objectives

We welcome and strongly support the action-oriented nature of the working document's outlook on the action plan. We support fully the reflection of more recently adopted goals and objectives relevant for alcohol policy development in other global strategies and action plans.

We emphasize the short note that the operational objectives reflect the lessons learned in implementing the WHO GAS in the last decade. This is an essential quality standard of the action plan. That is why the analysis of the challenges and opportunities matters and we encourage WHO to better reflect the analysis of lessons learned in the operational objectives.

The SAFER initiative and policy package should feature in the introduction to the operational objectives, including the monitoring and protection dimensions.

In support of the operational objectives, we propose a logical model, and we propose adding two more operational objectives that have gone missing from the WHO GAS' objectives.

What we want to add

We propose to add two more operational objectives. Our analysis of the working document and the WHO GAS has shown that some elements of the original objectives went missing. While we support the operational objectives as suggested in the working document, we are convinced that the following elements should also be included in the action plan's operational objectives:

- NEW 7. Increased technical support to, and enhanced capacity of, Member States for developing and implementing the most cost-effective alcohol policy solutions, and for protecting those against alcohol industry interference; and
- NEW 8. Improve and strengthen the global and regional infrastructure for alcohol policy development in order to build momentum, exchange best practices, and facilitate partnerships and international collaboration.

Objective 7 consists of elements that have been present in objective 3 of the WHO GAS but that is missing from the operational objectives.

Objective 8 builds on missing elements contained in WHO GAS objective 4.

Proposed operational principles

We welcome and support the operational principles. We believe they add value in support of the overarching guiding principles of the WHO GAS. We believe this section is important and should be expanded, for examples as in WHO Global Action Plan for Physical Activity (GAPPA).

Therefore, we propose at this stage to add the following operational principles:

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- Prevention first
- Proportional universality
- Policy coherence
- Alcohol in all policies – mainstreaming approach
- Whole-of-government approach
- Engagement and empowerment of policy-makers, people, families, and communities (in a slight adjustment to the principle already on the list, last bullet point)

Regarding proposed key areas for global action

Broadly, we welcome and support the set of 6 key areas for global action, including the quantity and quality of the actions detailed. Some elements can be improved, some elements are missing, and some elements should be reworked while some others should be removed – as outlined in Movendi International’s submission, which we endorse.

We propose to reframe and rework the key areas for global action as “framework for action”, as for example the WHO Global Action Plan for Physical Activity (GAPPA) does. This allows to streamline the actions and create greater coherence across the action areas.

From our perspective it is important that the action plan makes it clear who has primary responsibility and obligation to implement the WHO GAS and achieve global targets – the Member States and WHO. Therefore, we propose to include civil society and international partner action in a separate section and to focus Member States and WHO action in the “Framework for action”.

In our view, key area 1 for global action is the core of the action plan, with key areas 2 to 5 having supportive function, and with area 6 underpinning all other actions but in turn benefitting from success in area 1.

Therefore, we outlined above the importance of the SAFER alcohol policy blueprint receiving special focus in the action plan. To that end, the area one targets should be grouped in terms of alcohol consumption targets and alcohol policy developments targets, with an overall target and targets that correspond to the SAFER measures, similarly to our addition to the setting the scene section above.

Global action on reporting about alcohol consumption, related harm and policy development should reflect the magnitude and urgency of addressing the alcohol burden. In tobacco control, a global report is launched every year. For alcohol prevention and control that should be the ambition, too.

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Role of the alcohol industry

We strongly disagree with the role assigned to the alcohol industry in the working document, especially in the key areas for global action. The working document remains incoherent, as is the WHO GAS.

It is critical that the action plan overcomes this incoherence within the frames of the mandate given by Member States through the WHO GAS but in line with a decade of evidence about the alcohol industry's role in delaying, derailing and destroying attempts to implement the WHO GAS.

In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that neither self-regulation, nor corporate social responsibility has brought any positive changes to the alcohol burden; that the alcohol industry is interfering against WHO-recommended alcohol policy solutions, delaying, derailing and destroying attempts to implement the WHO GAS; that the alcohol industry has a fundamental conflict of interest, for instance because large parts of their profits come from heavy alcohol use; and that WHO will desist with the dialogue with the alcohol industry.

Regarding improvements to the global governance and infrastructure for alcohol policy development

Governance and infrastructure matter for the quality and frequency of dialogue and discourse, for the exchange of best practice, for the facilitating leadership and commitment and for advancing advocacy and fund-raising efforts.

Compared to other areas of global health, the infrastructure for alcohol policy development is under-developed and remains inadequate. The reasons are clear and have indirectly addressed in the working document. Therefore, we are convinced that the action plan benefits from including a section about infrastructure and governance improvements – applying lessons learned from other health areas.

On the level of global action:

1. There is no global day/ week to raise awareness about alcohol harm and policy solutions – like there is for tobacco and many other health issues.
2. There is no global ministerial conference on alcohol under the guidance of WHO – like there is for mental health, for ending tuberculosis or for road safety for example.
3. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
4. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.

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5. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).
6. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.
7. There is no functioning international network of alcohol focal points, largely due to lack of funding and capacity to coordinate and arrange meetings – like there is for NCDs government focal points.
8. There is no mechanism for alcohol policy to be on the agenda of WHO governing body meetings in regular, meaningful intervals – like there is for other public health priority issues and despite the fact that alcohol harm extends far beyond NCDs.
9. There is no civil society participation in WHO's expert groups/ committees on alcohol – like there is for other health issues and despite the fact that civil society participation has often been the driver for action and accountability.
10. For tobacco, WHO has the Tobacco Free Initiative and the MPOWER package. But there is no specific WHO program on alcohol – despite the existence of SDG 3.5 – to act as custodian for all challenges listed above and to ensure a response to the alcohol burden commensurate with the magnitude of harm.
11. There is still insufficiently developed methodology for understanding the real burden of alcohol and the real potential of alcohol policy implementation.

On the level of national action:

1. There are few/ no countries with an institutionalized permanent coordinating entity for alcohol policy development and implementation consisting of senior representatives from all relevant departments of government as well as representatives from civil society and professional associations,
2. There are few/ no countries that conduct regular (annual) alcohol policy roundtables/ meetings with national leaders and civil society to discuss latest alcohol policy issues,
3. There are few/ no countries with distinct mechanisms to safeguard alcohol policy development and implementation against alcohol industry interference,

Until 2030, there should be significant progress in terms of these infrastructure and governance elements and therefore we propose they be included in the section of the action plan called “Infrastructure”.

IOGT-VN

Department/Unit: *NGO*

Country/Location: Viet Nam

URL: iogt.org.vn

Submission

WHO should encourage the policy makers in Vietnam to work further on Alcohol Prevention in the rural and mountainous areas. The recent policy on prohibiting drivers not to drink start being effective but not totally and not quite strictly. Traffic accidents and family violences are still being happened everywhere.

Attachment(s): 0