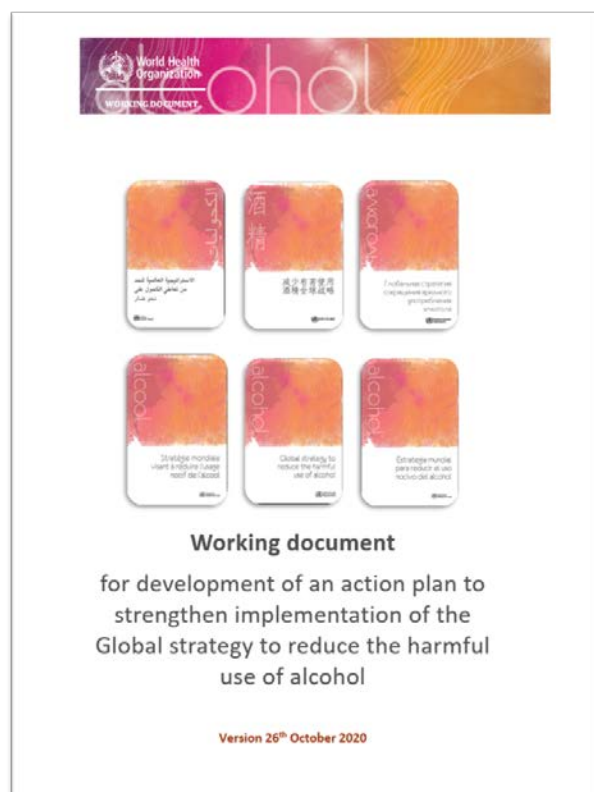


Development of an action plan (2022-2030) to effectively implement the WHO Global strategy to reduce the harmful use of alcohol



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 DOUCMENT

Volume II

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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 will conduct 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 to 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 (ADAA)

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 de Bebidas
Canadian Centre on Substance Use and Addiction
CEEV, Comité Européen des Entreprises de Vins
Center for Indonesian Policy Studies
Center for Law and Policy Affairs
Center for youths mental health and drug abuse prevention, Nigeria
Cervecedores 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
Committee 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 Technology 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 Hilkiah 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

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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, Kompetansesenter rus region sør (A norwegian resource centre for drug and alcohol problems)

Kookiri ki Taamakimakaurau 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 - ZPPP Browary Polskie
Polish Spirits Industry
Polish Vodka Association
Portman Group
Portuguese Brewers Association
Prevention Network/Michigan Coalition to Reduce Underage 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

Tairāwhiti Community FASD Working Group

Tanzania Network Against Alcohol Abuse - TAA-net

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

Istituto Bruno Leoni

Country/Location: Italy

URL: <http://www.brunoleoni.it/>

Submission

Among various programs focused on raising awareness of the issue and building member's states technical capacity, the Action Plan crucially encourages the implementation of three restrictive measures to curb the consumption of alcoholic beverages: (1) Regulating commercial and public availability of alcohol, (2) restricting or banning alcohol advertisings and promotions, (3) using pricing policies such as excise tax increases on alcoholic beverages. These recommendations, prohibitionist actions that involve the rising of excise taxes and the banning of products and advertising will most likely be ineffective or, worse than that, result in negative externalities by achieving the opposite results than those intended.

This scope expansion by the nanny-state would not only endanger the principle of free-speech, but it would probably be ineffective as well.

One argument often given in favor of these restrictive measures is the idea that the promotion of alternatives to alcohol consumption and advertising campaigns highlighting the dangers of such beverages did not achieve the intended results, thus requiring stronger actions, but

empirical research has demonstrated that advertising for tobacco and alcohol does not influence consumer behavior in any decisive way, as it doesn't for other types of products.

Alcohol being subject to inelastic demand, banning or restricting advertising will probably force sellers and producers to find other, more expensive ways to advertise their product. In addition, the inability to advertise will discourage new players in the market and stifle innovation, thus possibly leading to worse products, which could be even more harmful.

Banning advertisement of alcoholic products and limiting their availability will substantially affect the freedom of choice of consumers, who will have less opportunities to determine their best interested in a rational and balanced manner. This will give undue advantage to certain, well-known alcohol producers who may engage in unfair market practices.

In addition, the tax won't affect wealthier consumers' choices much, while it will considerably restrict the choice of poorer buyers. Because the demand for alcohol among the latter group will not just disappear, higher taxes on such products will only fuel black-market practices. These would be also stimulated by the loss in revenues on the side of retailers and producers, which will encourage tax evasion.

However, because there is an argument to be made about the social cost of alcohol consumption, especially in the form of burden on the health care system, a financial strategy should focus on matching the cost of taxation for the individual to the resulting externalities.

Moreover, a design should be implemented which does not punish moderation, but instead discourages overconsumption. This could be achieved by taxing the volume of alcohol consumed instead of the

product's price, or by generally applying uniform specific excises to minimize price gaps, reduce transactional burdens and avoid perverse effects such as races to the bottom or brand repositioning.

Attachment(s): 1

00311_70_alcohol-who-bruno-leoni-institute.pdf

Banning and Taxing Alcohol Consumption Is Counterproductive

The WHO Executive Board has recently called for an urgent and more concerted action to tackle the issue of alcohol abuse across the world. Following the publication of *the [2013-2020 Global Action Plan for the Prevention and Control of Non-Communicative Diseases](#)* by the WHO and the *2019 Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases*, the Board has recommended a wide range of measures and policy options aimed at reducing the damaging impact of alcohol consumptions on individuals and society.

Among various programs focused on raising awareness of the issue and building member's states technical capacity, the *Action Plan* crucially encourages the implementation of three restrictive measures to curb the consumption of alcoholic beverages: (1) Regulating commercial and public availability of alcohol, (2) restricting or banning alcohol advertisings and promotions, (3) using pricing policies such as excise tax increases on alcoholic beverages. Considering these options as the 'best-buys' following a cost-benefit analysis, the WHO presented the SAFER initiative, which includes these regulatory and financial tools. In spite of the alleged cost-benefit analysis guiding these recommendations, prohibitionist actions that involve the rising of excise taxes and the banning of products and advertising will most likely be ineffective or, worse than that, result in negative externalities by achieving the opposite results than those intended.

Banning or severely restricting alcohol advertising has been described by the WHO as the most efficient and effective way to [protect younger generations](#) from the abuse of alcoholic beverages. The argument goes that new types of online and social media communication have expanded the scope and breadth of such advertisement campaigns, which primarily end up influencing decisions of adolescents too young to be legally drinking. Because a proper and specific regulation of such digital environment involves considerable costs, the more efficient solution is to directly ban or restrict all types of alcohol-related advertisement. This is clearly a [logical fallacy](#), given that enforcing a general ban to protect underage teenagers would imply that all citizens are to be treated as such. This scope expansion by the nanny-state would not only endanger the principle of free-speech, but it would probably be ineffective as well. Empirical research has demonstrated that advertising for tobacco and alcohol does [not influence consumer behavior](#) in any decisive way, as it doesn't for other types of products.

Alcohol being subject to inelastic demand, banning or restricting advertising will probably force sellers and producers to find other, more expensive ways to advertise their product. In addition, the inability to advertise will discourage new players in the market and [stifle innovation](#), thus possibly leading to worse products, which could be even more harmful. The restriction of the advertising industry would moreover have negative spillovers in other sectors of the economy, such as the sport business and the media industry, which often rely heavily on advertisement of beverages for the revenues. On a slightly different but nevertheless related note, some have criticized the relative ['double-standard'](#) adopted by proponents of alcohol-advertisement bans. Indeed, one argument often given in favor of these restrictive measures is the idea that the promotion of alternatives to alcohol consumption and advertising campaigns highlighting the dangers of such beverages did not achieve the intended results, thus requiring stronger actions. The logic employed here seems flawed, given that if one type of advertisement does not appear to be influencing consumers' choices, one may wonder why any other type should.

Banning advertisement of alcoholic products and limiting their availability will [substantially affect the freedom of choice of consumers](#), who will have less opportunities to determine their best interested in a rational and balanced manner. This will give undue advantage to certain, well-known alcohol producers who may engage in unfair market practices. The [Cato Institute](#) has moreover presented an excellent analysis of American Protectionism, highlighting the failure of the project and the many unexpected externalities caused by the ban. The most important ones are the increased danger of alcohol-

consumption, rising crime rates, burdens on the judicial and administrative system and the ensuing corruption of law-enforcement, notwithstanding the opposite effect to the one intended.

These problems are also to be expected when excise taxes or similar financial tools are implemented, which, unless well-designed, tend to disadvantage the wrong groups and add inefficient dead-weight losses to the economy. All excise taxes will necessarily be [regressive](#) in character, given that they will tend to harm poorer members of society more compared to wealthier ones. Taxes on alcoholic beverages aimed at raising prices will face an inelastic demand curve and therefore exacerbate social inequality. For wealthier consumers the tax won't affect their choices much, while it will considerably restrict the choice of poorer buyers. Because the demand for alcohol among the latter group will not just disappear, higher taxes on such products will only fuel [black-market practices](#). These would be also stimulated by the loss in revenues on the side of retailers and producers, which will encourage tax evasion.

Complex excise taxes, such as [ad valorem taxes](#) that make the rate of taxation dependent on the product price, will also create distortions caused by increased transaction costs. Being difficult to implement correctly, these programs will be more likely to fail and leave behind a long trail of negative externalities. However, because there is an argument to be made about the social cost of alcohol consumption, especially in the form of burden on the health care system, a [financial strategy](#) should focus on matching the cost of taxation for the individual to the resulting externalities. Given that alcohol consumption already earns the government revenue through [existing forms of taxations](#) like VAT, there is no need for an excessive and exaggerated excise tax on this product to off-set its externalities. Moreover, a design should be implemented which does not punish moderation, but instead [discourages overconsumption](#). This could be achieved by taxing the volume of alcohol consumed instead of the product's price, or by generally applying [uniform specific excises](#) to minimize price gaps, reduce transactional burdens and avoid perverse effects such as races to the bottom or brand repositioning.

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World Health Organization. *Evidence on excise tax systems and their challenges*.

ISTITUTO SUPERIORE DI SANITA'

Department/Unit: *OSSERVATORIO NAZIONALE ALCOL - WHO CC ITA 79*

Country/Location: Italy

URL: www.iss.it

Submission

The proposal is aimed at renewing the overall approach (areas, targets and key components) followed by the previous strategy one (2010) integrating the results from last consultations with the lessons learned, new goals and objectives and other actions merged during the last 10 years. However, whereas the ongoing Global Strategy gained mainly by the long experience of the European Alcohol Action Plan and the overall framework set by a longstanding and consolidated exercise based on the full involvement of EU MS counterparts supporting a much more practical adoption of measures that are currently part of the National Strategies in charge for the next years, this new draft document looks like unbalanced by the new entries (such as SAFER) not providing a comfortable idea of the continuity on what still needs to be done .

This is evident since the beginning of the draft with a discontinuity between the introduction and the articulation of the global strategy needing a much more systematic approach.

MS are committed in the objectives of the NCDs and SDGs action plans that should be a consistent part of the new global strategy but mentioned almost in the introduction and poorly recalled in the rest of the document and in the action areas.

Compared to the previous edition and the main source of inspiration (the European action plan), the document is less performing and probably in need for an in depth rearrangement to create a necessary, much more visible continuity with the previous strategies.

The choice of proposing new action areas (or modifying existing ones), which are now part of the “culture” acquired and introduced by policy and decision-makers and mainly used to inspire and consolidate the different national strategies and prevention plans, introduces a strong criticality for adherence/compliance to multi-year strategies already in progress at the national level and already projected at least for the next 3 years (being all the strategies ending in 2020 and therefore prolonged due to a late or missing availability of new ones at EU as well as International level).

The overall draft is still too abstract and lacking in providing all the elements /explicit information easing the full involvement for actors and stakeholders to identify themselves in the role (and mandate) to which the global strategy should refer to; the missed reference to the ten strategic areas of the ongoing Global Strategy does not facilitate a still requested and hopefully increasing engagement into the recommended 10 target areas for policy measures and interventions which should continue to represent the core areas of activity that should have been subject to additions and changes to be integrated according to the need analysis and lessons learnt.

As a matter of facts not all the Member States starts from the same level of implementation and there is a concrete possibility that many of them may considered much more relevant to focus on areas in

which, as an example, the best buys are not the best fitting with their own capacity to ideally deal with national priority. This will generate frustration in being not “eligible” for the new areas where they should be committed in implementing the “classical” areas, actions and targets presenting, by the way, a still huge need for public health response as still not reaching an adequate level of policy response and targets. States that have not yet activated actions in the individual areas of the current global strategy have to be supported, while other nations would be much more keen to benefit from reviewing, adjusting and strengthening the ongoing initiatives both introducing new actions for the new areas and continuing as well to refer to their existing national strategies/plans.

The actions currently included in the proposal as statements should be transformed into concrete objectives to be achieved within the existing areas of action widening their added value.

The 4 "key components" of the previous global strategy, in the new proposal are 6 “action areas” with the introduction of:

- a. the "action area 1: implementation of high-impact strategies and interventions” for SAFER options and
- b. the "action area 3: partnership, dialogue and coordination" to underline the role of country focal points and WHO national counterparts as facilitators of country cooperation, knowledge transfer and capacity building.

However, there is no homogeneity in the description of the 6 areas: the new action area 1 on the SAFER initiative is more detailed compared to the other areas and there are overlapping with some SAFER options and interventions included in other action areas while no adequate space is given for interventions not included in the SAFER initiative.

Furthermore, being not a guarantee that the SAFER initiative (as in the action area 1) is implemented, the SAFER policy options and interventions should be adequately included in the other action areas (currently is not in the draft) but it is not, for example the access to the brief intervention that is no longer mentioned anywhere in the document, even if the word "treatment" is included 29 times...(if “treatment” includes "brief intervention" needs to be clarified also because during MS consultations in Prague an area TREATMENT was judged as an explicit needed area and several indicators were discussed).

Thus, SAFER, as it stands , compress all the existing targets that are well identified in the ongoing global strategy and influence a sort of underscoring in terms of priority of all the activities included in SAFER, namely a strategy in the strategy, a concrete possibility that could even represents a sort of internal competitor with the other areas.

Introducing the action area 1, as a matter of fact a toolkit that has been transformed into an area or a target as a whole, gives the impression to introduce a confusion with the rest of the proposal not

supported by same level of detailed support but “only” with a sort of series of principles whose implementation is not completed with concrete steps, actions to ease the activation on the new strategic areas.

That’s to say that it should be considered the opportunity to continue to combine the overall approach given by the previous key components and all the target areas that needs, also in case will list the current 6 action areas, to be presented into a different “logical” order , with the action area 1 aimed at implementation as the last one.

Multisectoral policies” beyond the health sector are mentioned many times but not described (and when described, not comprehensive) and not linked to the additional relevant strategic documents.

The proposed actions for economic operators in the proposal looks like not pushing for a suasion facilitating “the appropriate engagement of civil society and economic operators”: misunderstandings need to be avoided stressing in the introduction that their activities must be aligned with, to be coherent with, in support of...in collaboration with the initiatives coordinated at country level. It must be reinforced the principle and message that prevention is a public health interest, a mission and mandate only for competent authorities, organizations, institutions who are legitimated into a role that industry cannot play.

Policy responses is mentioned many times in the proposal (with some overlapping) but not the health service response (and social) that could have more space as a relevant part of the solution but also of the problem.

If not included as targets of the proposal, some indicators actually used by MS will be missed and, as an example, if not included in the annex 1 (for example for drink driving measures) there will be no specific monitoring on sensitive areas; this makes really hard the continuity of current and future national strategies.

Attachment(s): 0

Japan Spirits & Liqueurs Makers Association (JSLMA)

Country/Location: Japan

URL: <http://www.yoshu.or.jp/index.html>

Submission

In 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, we would like to share the following views and comments based on our own experiences:

1. Future Action Plan should remain focused on tackling harmful use of alcohol
2. Future Action Plan should maintain policy option menu for member states considering of their national context
3. Future Action Plan should keep encouraging whole of society approaches and recognizing the role and contribution of private sectors

Thank you

Attachment(s): 1

00428_63_jslma-submission-who-web-based-consultation-december-2020.pdf



Japan Spirits & Liqueurs
Makers Association

**JSLAM response to 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**

December 2020

Japan Spirits & Liqueurs Makers Association (JSLMA) is one of the leading associations of beverage alcohol producers in Japan representing 81 producers of whisky, brandy, liqueurs and other spirits in Japan. JSLMA and its member companies are fully committed to keep our high standards both on quality and responsible marketing of our products, together with producer associations of another category such as beer, wine, sake and shochu in Japan. JSLMA is one of the founding members of World Spirits Alliance (WSA).

JSLMA welcomes the opportunity to participate in this consultation and contribute its views and observation related to the working document and the further development of Global Strategy to reduce the harmful use of alcohol.

We highly appreciate the achievements of the WHO global strategy to reduce the harmful use of alcohol since 2010 and continuous effort by WHO member states (MS), secretariat and various stakeholders to develop and implement the Strategy.

The progress of the global actions to reduce the harmful use of alcohol, highlighted by 2010 Global Alcohol Strategy (GAS), Global Action Plan for the Prevention and Control of NCDs and the UN Political Declaration on NCDs (UNPD), encouraged the Japanese Government to adopt 'The Basic Act to Reduce Alcohol Related Harm' in 2014 and 'National Action Plan to Reduce the Alcohol Related Harm' in 2016. We are very proud that JSLMA has been involved in the government's hosting stakeholders meeting for the implementation of the National Action Plan from the beginning.

In 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, we would like to share the following views and comments based on our own experiences:



Japan Spirits & Liqueurs
Makers Association

1. Future Action Plan should remain focused on tackling harmful use of alcohol

- To be consistent with GAS and UNPD, the action plan should remain focused on reducing harmful use of alcohol. The action plan could further examine the positive trend in reducing harmful use of alcohol and its success factors and could encourage to expand the good practices.
- In Japan National Action Plan was focused in three areas with monitoring framework; 1) Reducing the underage drinking, 2) Reducing the drinking during pregnancy, 3) Reducing the ratio of risky drinkers. The first five years review on the Action Plan is ongoing and all related party including the private sector are discussing next five years plan for strengthening of reducing alcohol related harm. We believe that the case in Japan is advanced but not too unique, and that this kind of good practice can be transplanted in various MS.
- The working document refers both reducing harmful use of alcohol and reducing per capita consumption, and they are sometime used in mixed manner. It also refers the reducing consumption as an operational objective. Reducing per capita consumption is one of three global indicators for the GAS. As mentioned in the above case in Japan, MS should establish their own action plan with challenging but traceable and achievable goals which are solely focused on reducing harmful use of alcohol within the national context.

2. Future Action Plan should maintain policy option menu for member states considering of their national context

- The challenges to tackle harmful use of alcohol vary by region and country or even by cultural groups and generations within them. As mentioned above, in Japan the National Action plan sets the goals of reducing the harmful use of alcohol focusing on the three vulnerable groups - underage, pregnant and risky drinkers. It also sets three strategic goals to establish; 1) prevention and education, 2) brief intervention and seamless medical network, 3) consultation and support by society. First five years review is ongoing and the next five years plan could have different targets and goals depending on the progress. This is the reason why we believe optional policy menu and flexibility by MS is key for success to the national action plan to reduce the harmful use of alcohol.
- With this back ground the working document should not overemphasizes the adoption of the SAFER initiative to MS. We appreciate the introduction of 'best



Japan Spirits & Liqueurs
Makers Association

buys' as most cost-effective actions. The 'best buy' actions, however, are most suitable for reducing the overall consumption, of which includes the responsible and well-informed consumers on the harmful use of alcohol.

- We know that the target approaches require more resources, data base and involvement by intra government agencies and multi stakeholders. We know also that it constructs more effective whole of society approaches in the end, as it does in Japan.

3. Future Action Plan should keep encouraging whole of society approaches and recognizing the role and contribution of private sectors

- The private sector actors in production and trade of beverage alcohol have been key members of the Japanese Government hosting stakeholders meeting on National Action Plan to Reduce Alcohol Related Harm. The role and responsibilities of our sectors in the Plan are described in 'The Basic Act to Reduce Alcohol Related Harm'. Based on the mutual understanding of our role by the government and various stakeholders we dedicate ourselves much more to contribute reducing harmful use of alcohol.
- As the producer and marketer of beverage alcohol products, we believe that we understand the harmful elements of alcohol more than anyone else, and we know we have no business sustainability, unless we conduct our responsible marketing and maintain our standard high on product quality and business practices.
- The working document describes how economic operators in the area of alcohol beverage production and trade to be engaged in various Action areas. Some of them are very restrictive and limiting our engagement in context of whole of society approaches, which is not the case working effectively in Japan. It also describes conceptually the commercial interests as barrier against progress.
- To be consistent with GAS and UNPD the future action plan should keep encouraging whole of society approaches where the role and contribution of private sectors to be recognized properly.

We would like to thank the WHO secretariat again for holding this consultation under current circumstance. We are happy to provide any additional information and clarification.

Joint Submission of NCD Alliance, Vital Strategies, UICC, World Heart Federation, World Obesity Federation and Movendi International

Country/Location: Sweden

Submission

Joint submission - WHO Consultation on action plan to improve implementation of the WHO Global Alcohol Strategy

The 2010 WHO Global Alcohol Strategy encourages the alcohol industry to contribute to the prevention and reduction of alcohol harm in their core roles as economic operators. Furthermore, the Political Declaration of the third high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases in 2018 invited the alcohol industry to strengthen their commitment to eliminate marketing, advertising and sale of alcoholic products to minors.

We question the role given to the alcohol industry in the working document to develop an action plan for better implementation of the WHO Global Alcohol Strategy.

Due to the fundamental and irreconcilable conflict of interest, the alcohol industry has not lived up to these objectives over the last ten years and has instead actively worked against them.

The alcohol industry has a track record of

- driving heavy alcohol use for profit maximization;
- political interference around the world to delay, derail, and destroy the development of Best Buy alcohol policy solutions;
- continuing targeting and exposure of children and youth to alcohol advertising, sponsorship and promotion;
- consistent failure to deliver sufficient public health outcomes via self-regulation; and
- counterproductive and even harmful corporate social responsibility campaigns subverting effective public health measures.

Clearly, WHO's engagement with the alcohol industry has not yielded any public health gains but has been used by the alcohol industry to re-cast their image as a legitimate stakeholder in policymaking, and interfere in effective implementation of the WHO Global Alcohol Strategy.

We therefore suggest WHO reassess the role assigned to the alcohol industry in the working document. In line with independent scientific evidence, the role of the alcohol industry should be reduced to providing data on alcohol consumption and alcohol availability at global, regional and national levels.

WHO should desist with dialogues with the alcohol industry.

Lastly, we request WHO improve guidance to Member States on how to identify, avoid, and manage conflicts of interest and how to protect against interference of the alcohol industry in public health policy-making.

On behalf of:

1. NCD Alliance
2. Vital Strategies
3. Union for International Cancer Control
4. World Heart Federation
5. World Obesity Federation
6. Movendi International

Attachment(s): 1

00509_29_final-joint-submission-ncds-alcpol-ncda-vs-uicc-wof-whf-movendi.pdf

Joint submission - WHO Consultation on action plan to improve implementation of the WHO Global Alcohol Strategy

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Lastly, we request WHO improve guidance to Member States on how to identify, avoid, and manage conflicts of interest and how to protect against interference of the alcohol industry in public health policy-making.

On behalf of:

1. NCD Alliance
2. Vital Strategies
3. Union for International Cancer Control
4. World Heart Federation
5. World Obesity Federation
6. Movendi International

Kenya Association of Muslim Medical Professionals (KAMMP)

Department/Unit: *Mental Health Department*

Country/Location: Kenya

URL: www.kammp.or.ke

Submission

The Kenya Association of Muslim Medical Professionals (KAMMP) appreciate the opportunity to be a part of the consultation process 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. We have gone through the document and would like to make the following comments:

To achieve SAFE initiative, clear guidelines on what is expected of Economic operators should be stipulated and come up with stringent measures when they do not abide by their core roles.

Advocacy and awareness creation on effect of use of alcohol in children Should be prioritized, school and community programs implemented targeting this population.

We are suggesting if the Economic operators have to facilitate any activities they should only do it in collaboration with civil society organizations, professional associations, research institutions, including mutual help groups and associations of affected individuals and their family members, to ensure appropriate information is conveyed, implementation and enforcement of effective measures to reduce the harmful use of alcohol, including support of education and training programmes are done appropriately in line with the objectives and principles of the Global Strategy.

Attachment(s): 1

00490_14_who-working-document-consultation-to-reduce-the-harmful-use-of-alcohol-kammp-35214.pdf



KENYA ASSOCIATION OF MUSLIM MEDICAL PROFESSIONALS

P. O. Box 1255-80100,
Email: info@kammp.or.ke
Website: www.kammp.or.ke

THE GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL

The Kenya Association of Muslim Medical Professionals (KAMMP) appreciate the opportunity to be a part of the consultation process 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. KAMMP is a not for profit Non Governmental organization comprising of Muslim healthcare workers in Kenya from different cadres and professional bodies. Having gone through the document we would like to make the following comments:

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

We agree that there is little or no progress in some part of the world in reducing harmful Alcohol consumption despite having very detailed and comprehensive policies in place in most of these countries. The SAFER initiative will not be achieved if we do not seriously and specifically tackle the alcoholic beverage production, trade and marketing strategies of the Economic operators whose aim is to enable them sell their products. We suggest there should be clear guidelines on what is expected of this specific group of stakeholders and come up with stringent measures when they do not abide by their core roles.

ACTION AREA 2: ADVOCACY, AWARENESS AND COMMITMENT

We suggest emphasis on the effect of Alcohol use on the mental health of the individual using it and the adverse effects it has on children who are exposed to it at a very early age and the indirect effect it has on the mental health of children who are brought up in dysfunctional families due to Alcohol use disorder in one or both parents.



KENYA ASSOCIATION OF MUSLIM MEDICAL PROFESSIONALS

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Apart from having an international day of awareness on the harmful use of alcohol it will be prudent to have school based and community based awareness programs aimed at empowering children and adolescent regarding the effects of alcohol, consequences of using alcohol at their age and early detection and intervention of alcohol use disorder in this age group.

We would also like to see a separate section dealing with local brews which is a great menace in our communities and has detrimental effect in those who consume these types of alcoholic beverages.

ACTION AREA 4: TECHNICAL SUPPORT AND CAPACITY-BUILDING

We support capacity-building entirely but a bit skeptical when it comes to the Economic Operators facilitating the activities and being left independent to monitor and control themselves and make sure that their activities will not be biased and outside their core roles. We are suggesting that if they have to facilitate activities then it should be done in collaboration with civil society organizations, professional associations, research institutions, including mutual help groups and associations of affected individuals and their family members, to ensure appropriate information is conveyed, implementation and enforcement of effective measures to reduce the harmful use of alcohol, including support of education and training programmes are done appropriately in line with the objectives and principles of the Global Strategy.

Khmer Youth Association

Department/Unit: *Youth*

Country/Location: Cambodia

URL: <http://www.kya-cambodia.org/>

Submission

Adult drinking habits, including parents and community people, making children and youth to drink alcohol. Children and youth follow bad negative habits and mindsets from old people because they believe that they should drink alcohol when they meet or catch up. Moreover, some NGOs and local authorities still drink alcohol during the new year and public holidays to celebrate it because they do not understand the bad effect of alcohol and the effect on young people follow them. The target groups to reduce alcohol consumption, we should focus on some NGO staffs and authorities.

Attachment(s): 1

00438_71_movendi-members-who-workingdoc-consultation.pdf

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

Khmer Youth Association (KYA) is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

Khmer Youth Association is promoting youth participation in human rights, democracy, peace building, health, gender equality, education and vocational training for young people in Cambodia.

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.

Kookiri ki Taamakimakaurau Trust

Country/Location: New Zealand

Submission

Please see attached.

Attachment(s): 1

00535 Kookiri Submissions to WHO on alcohol Dec 2020 reduced.pdf



Kookiri ki Taamakimakaurau Trust

'Te kaitiakitanga whakaiti i ngaa hua kino ki te Maaori. Ko te karere o te iwi Maaori whai kaha'
'Minimise the harmful effects of alcohol on Maaori. Maaori voices matter'

10 December 2020

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'

Teenaa koutou | Greetings to you all

Mehemea kaaore he whakakitenga ka mate te iwi

'Without leadership the people will perish'

Kiingi Tuukaaroto Matutaera Pootatau Te Wherowhero Tawhiao, Second Maaori King

Kookiri ki Taamakimakaurau Trust, is a Maaori (Indigenous peoples) organisation in Aotearoa New Zealand. We are committed to, amongst other things, preventing and minimising the harmful effects of alcohol on its people.

We would like to acknowledge and thank you for the opportunity to provide feedback on the Working Document so we can strengthen the response to alcohol as a harmful commodity.

If you would like more information about Kookiri ki Taamakimakaurau Trust, Maaori and how we are disproportionately affected by alcohol harm or this submission please contact the writer.

 David (Raawiri) Ratuu

Tiamana Whakahaere | Executive Chairman

Kookiri ki Taamakimakaurau Trust

PO Box 13-597 Onehunga. 1643

Taamakimakaurau, Aotearoa.

Tau Waea | +64 9 2640972 Waea Puukoro | +64278 333 350 Karere Rorohiko | david@kokirikt.co.nz

Introduction

1. Kookiri ki Taamakimakaurau Trust acknowledges the World Health Organization's consultation process on the development of an Action Plan (2022-2030) to implement the Global Strategy to reduce the harmful use of alcohol.
2. Alcohol is a significant cause of mortality and morbidity across the globe, causing over 3 million deaths annually and over 5% of disease burden.¹ It is therefore disconcerting that global projections are forecasting an increased prevalence of alcohol consumption.²
3. Te Tiriti o Waitangi (Treaty of Waitangi) is the founding document of Aotearoa New Zealand and signifies the special relationship between Maaori and the Aotearoa New Zealand government, as outlined in the New Zealand Public Health and Disability Act 2000. Te Tiriti was originally signed by the British government when Aotearoa was colonised in 1840. This Act enshrines the principles of Te Tiriti and is intended to provide equitable outcomes for Maaori.³ This includes in relation to alcohol.
4. Alcohol (or waipiro in our language, meaning 'stinking water') is a significant cause of harm to Maaori communities, and is a consequence and cause of inequity for our people.⁴
5. The disparate inequities in health and social outcomes because of waipiro for Maaori reflect on-going breaches of Te Tiriti o Waitangi which are avoidable, unethical, and unjust.⁵ The inequities between Maaori and non-Maaori are not due to whakapapa (genealogy) or 'choice', with extensive evidence highlighting the systemic failures for Maaori is due to colonisation.⁶
6. Maaori lived for over 400 years without any form of alcohol in Aotearoa New Zealand until it was introduced by European explorers and sailors in the late 1700s.⁷ This means the entirety of the burden of alcohol-related harm for Maaori is attributable to extrinsic factors.⁸

¹ World Health Organisation. Alcohol. 2020 https://www.who.int/health-topics/alcohol#tab=tab_1 (accessed Dec 6, 2020).

² 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.

³ New Zealand Government. New Zealand Public Health and Disability Act. 2000 <http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html> (accessed 6 Dec, 2020).

⁴ Hutt M. Te Iwi Maori me te Inu Waipiro: He Tuhituhinga Hitori: Maori & Alcohol: A History. Wellington: Health Services Research Centre, 1999.

⁵ Walker, K. WAI 2575: Issues of Tobacco, Alcohol and other substance abuse for Maaori. 2019 https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_155808738/Wai%202575%2C%20B030.pdf (accessed 27 May, 2020).

⁶ Waitangi Tribunal. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Ministry of Justice. 2019 https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf (accessed 23 May, 2020).

⁷ Hutt M. Te Iwi Maori me te Inu Waipiro: He Tuhituhinga Hitori: Maori & Alcohol: A History. Wellington: Health Services Research Centre, 1999.

⁸ Hutt M. Te Iwi Maori me te Inu Waipiro: He Tuhituhinga Hitori: Maori & Alcohol: A History. Wellington: Health Services Research Centre, 1999.

7. Maaori in contemporary Aotearoa New Zealand experience the highest burden of alcohol-related harm of all ethnicities.⁹ Maaori experience substantial inequities in hazardous alcohol use. In 2019/20, 43.7% of Maaori men were hazardous drinkers, compared to 34.3% of Pacific men and 31.4% among European/other men. Among women, the differences are more severe, with 29.2% of Maaori women reporting hazardous drinking, compared to 16.1% of Pacific women and 14.0% of European/other women.¹⁰
8. Other inequities for Maaori include:
 - a. Maaori are 1.8 times more likely to “binge drink”, or have a hazardous drinking pattern when compared to non-Maaori drinkers;¹¹
 - b. Maaori are 2.5 times more likely to die from an alcohol-attributable death when compared to non-Maaori;¹²
 - c. Maaori are twice as likely as non-Maaori to die from cardiovascular disease¹³, a disease linked to alcohol consumption;¹⁴
 - d. Maaori women are more likely to suffer from breast cancer than non-Maaori, a disease linked to alcohol consumption;¹⁵
 - e. Maaori are disproportionately harmed from living in close proximity to alcohol outlets;¹⁶
 - f. Maaori children are five times more likely to be exposed to alcohol marketing than European children in their everyday lives;¹⁷
 - g. Maaori comprising approximately half of Aotearoa New Zealand’s prison population, despite making up just 16.5% of country’s population.¹⁸ Police data shows that 31-46% of all offences are committed by persons affected by alcohol;¹⁹ and
 - h. Maaori being overrepresented as victims and perpetrators of violent crime. Police data shows that alcohol is involved in one in three cases of violent offending, and half of all homicides. Approximately 54% of physical assaults and 57% of sexual assaults occur when the perpetrator has been drinking.²⁰
9. Alcohol harm to Maaori has manifested over decades because of the failure of the Aotearoa New Zealand government to actively protect our people, often implementing racist and institutionally racist systems and policies. This is reflected in recent reports such

⁹ 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).

¹⁰ Ministry of Health. Annual Update of Key Results 2019/20: New Zealand Health Survey. 2020 <https://www.health.govt.nz/publication/annual-update-key-results-2019-20-new-zealand-health-survey> (accessed Nov 19, 2020).

¹¹ New Zealand Medical Association Reducing alcohol-related harm (Policy Briefing, May 2015) at 7

¹² New Zealand Medical Association Reducing alcohol-related harm (Policy Briefing, May 2015) at 9.

¹³ Ministry of Health “Cardiovascular disease” (Ministry of Health, 2 August 2018)

¹⁴ New Zealand Medical Association Reducing alcohol-related harm (Policy Briefing, May 2015) at 10

¹⁵ New Zealand Medical Association Reducing alcohol-related harm (Policy Briefing, May 2015) at 11.

¹⁶ Ayuka F, Barnett R, Pearce J. Neighbourhood availability of alcohol outlets and hazardous alcohol consumption in New Zealand. *Health Place* 2014; 1: 186–99.

¹⁷ 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* 2018; 53: 626–633.

¹⁸ Stats NZ. New Zealand’s population reflects growing diversity. 2020. <https://www.stats.govt.nz/news/new-zealands-population-reflects-growing-diversity> (accessed, 10 Dec 2020).

¹⁹ New Zealand Medical Association Reducing alcohol-related harm (Policy Briefing, May 2015) at 12.

²⁰ New Zealand Medical Association Reducing alcohol-related harm (Policy Briefing, May 2015) at 12.

as *Wai 2575 Stage One: Health Services and Outcomes Kaupapa Inquiry*²¹ and the New Zealand Health and Disability System Review²².

10. As such, we urge the WHO to take evidence-based action independent and objective from the influence of alcohol industry to assist the government in Aotearoa New Zealand to protect Maaori from this unjust and inequitable alcohol harm. We urge this not only for Maaori, but for all of our indigenous brothers and sisters across the globe, so that we can achieve our aspirations and health advancement.
11. In summary, we call on the WHO Secretariat to:
 1. Acknowledge the rights of indigenous people and prioritise actions related to reducing alcohol-related harm
 2. Inclusion of an explicit equity lens within the Working Document
 3. Restrict the entities with commercial vested interests from policy making
 4. Prioritise the implementation of the three 'Best Buys' as identified in the World Health Organisation's SAFER initiative
 5. Include timeframes for reviewing and reporting on the implementation of the Action Plan

Recommendation 1: Acknowledge the rights of indigenous people and prioritise actions related to reducing alcohol-related harm for us

12. We believe the consultation document would be strengthened by an acknowledgment of alcohol harm on indigenous people worldwide, who have been colonised. In the 19th and 20th centuries, 90% of the world was controlled, directly or indirectly, by European colonial powers. The impacts of colonisation are as significant today as they were in the 1800s.²³
13. Indigenous peoples around the globe are more likely to experience alcohol harm than other ethnicities living in the same country²⁴. In part, this is because many indigenous people now live-in disadvantaged circumstances such as higher poverty and reflects the trauma of colonisation meaning indigenous people more likely to drink alcohol hazardously.²⁵
14. Alcohol is normalised, affordable, promoted and widely available in Maaori communities, being the most used recreational drug in Aotearoa New Zealand and also the most harmful to society.²⁶
15. The drivers of alcohol-related harm for Maaori are structural and include the enduring marginalising and dispossessing effects of the colonisation of Aotearoa New Zealand, as

²¹ Waitangi Tribunal. *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. Ministry of Justice. 2019 https://forms.justice.govt.nz/search/Documents/WT/WT_DOC_152801817/Hauora%20W.pdf (accessed 23 May, 2020).

²² New Zealand Health and Disability System Review. 2020 <https://systemreview.health.govt.nz/> (accessed 9 Dec, 2020).

²³ Young, R. *Postcolonialism: A very short introduction*. 2003 Oxford University Press : Oxford.

²⁴ Gray D and Siggers S. *Indigenous Australian Alcohol and other drugs issues*. 2002 National Drug and Research Institute

²⁵ Ratima *et al* (2019) Indigenous voices and knowledge systems - promoting planetary health, health equity, and sustainable development now and for future generations. *Global Health Promotion*, 26, pp. 75-87.

²⁶ Nutt, D., King, L. and Phillips, L. (2010) 'Drug harms in the UK: a multicriteria decision analysis', *The Lancet*, 376(9752), pp. 1558-1565.

well as present economic and housing policies that continue to exclude Maaori from equal participation in society. Alcohol use in turn contributes to health and economic inequities experienced by Maaori.²⁷

16. Maaori, like all people across the globe, want our children to grow up in healthy and supportive environments as reflected in the Ottawa Charter for Health Promotion²⁸. This is so they can realise their full potential and break the intergenerational cycle of alcohol harm. This is not an unrealistic desire, but a human right as reflected in both the United Nations (UN) Convention on the Rights of a Child 1990²⁹ and the UN Declaration on the Rights of Indigenous People 2007.³⁰
17. Maaori in Aotearoa New Zealand are in the same position as our colonised, indigenous whaanau (family) around the world and we share their pain but unite in a vision for a healthier and more prosperous future for our children who deserve the best start in life.
18. We urge the WHO to honour its stated commitments to Maaori as an indigenous people, equity, and social justice by acknowledging and strengthening action regarding indigenous people.

Recommendation 2: Inclusion of an explicit equity lens within the Working Document

19. Equity in Aotearoa New Zealand is more complex. As Maaori are the indigenous people, they must be the priority. Kookiri believes that the Working Document should be strengthened with regards to the equity aspect. Whilst the equity gap is noted 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.
20. 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. Reducing the harmful use of alcohol will help achieve a number of health-related targets of the Sustainable Development Goals (SDGs), including those for maternal and child health, infectious diseases, noncommunicable diseases and mental health, injuries and poisonings. This will only be achieved with equity at the heart of policy and decision making.

²⁷ New Zealand Law Commission. Alcohol in our lives: curbing the harm. Wellington: New Zealand Law Commission. 2010 Apr 27.

²⁸ World Health Organisation. Ottawa Charter of Health Promotion. 1986 <https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference> (accessed 6 Dec, 2020).

²⁹ United Nations. Convention on the Rights of a Child. 1990 https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsq_no=IV-11&chapter=4&lang=en (accessed: 6 Dec, 2020)

³⁰ United Nations. UN Declaration on the Rights of Indigenous People. 2007 <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html> (accessed 6 Dec, 2020).

Recommendation 3: Restrict the entities with commercial vested interests from policy making

21. We acknowledge the Working Document's attempt to reduce the influence of the alcohol industry to subvert the action plan, but we feel the measures are unlikely to have much, if any, impact.
22. Our experiences and evidence suggest that inviting the alcohol industry as is included in this consultation document will prevent effective, proportionate and evidence-based policies that fail to protect all people, not just indigenous people.³¹
23. The alcohol industry is legally obliged to maximise profits for its shareholders; to prevent and minimise alcohol harm requires lower levels of alcohol consumption, or put another way, reduce alcohol sales. This conflict of interests means it is not feasible to have the alcohol industry and those with an interest in promoting health and wellbeing as partners at the same policy table. We feel it would be inconceivable that this would be permitted to occur with the tobacco industry as it once was. As such, we call for a similar response so alcohol policy can enjoy the same successes. This suggests the need for a policy response like the Framework Convention on Tobacco Control for alcohol, starting in particular with the equivalent to clause 5.3.³²
24. 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.³³
25. Kookiri are concerned to see alcohol industry entities are considered 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 and unacceptable to us.
26. Kookiri believe excluding the alcohol industry will reduce non-communicable disease who have influenced governments from taking action to protect indigenous people, as well as all people, from harmful commodities due to their commercial interests and lobbying. Without adequately tackling the Commercial Determinants of ill-health with an effective and proportionate policy response, such as that deployed in the successful tobacco journey, Maaori and other indigenous people will continue to endure disproportionate harm from alcohol. This is unjust and unacceptable.
27. We urge the WHO to lead by example and help governments put people's health before profits made from harmful commodities such as alcohol and have stronger restrictions, ideally exclusion, of industry from the action plan and any future policy making.

³¹ Kickbusch I, Allen L, Franz C. The commercial determinants of health. *Lancet Glob Health* 2016; 4: e895–6.

³² Casswell, S (2020) GAPC Conference 2020. Dublin.

³³ 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>.

Recommendation 4: Prioritise the implementation of the three 'Best Buys' as identified in the World Health Organisation's SAFER initiative

28. Governments need to create healthy environments alongside allocation of adequate revenue to provide assistance to the communities which can support those experiencing alcohol harm. Crucially, it is necessary government's implement evidence-based and supportive policies.
29. Kookiri believe 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
30. By committing to the WHO's SAFER initiative, and how this can also be applied to indigenous people globally, only then can we achieve our shared goal of achieving equity, preventing non-communicable disease, and achieving the WHO's own SDGs.
31. It is clear that we know the evidence and what we need to do to achieve health and social equity, as do we understand the barriers. As such, we call on the WHO to lead by example and follow the substantial and robust evidence base. This will enable and make it easier for Maaori to obtain the political mandate to provide protection for its people, and for all indigenous people, from the harmful influence and profits seeking practices of the alcohol industry.

Recommendation 5: Include timeframes for reviewing and reporting on the implementation of the Action Plan

32. Kookiri are surprised at the lack of detail around reporting expectations of Member States, 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.

Conclusion

1. Robust, proportionate and evidence-based action to prevent and minimise alcohol-related harm is required to improve the wellbeing of every indigenous person in Aotearoa New Zealand, and other indigenous people across the globe, for this generation and the next.
2. The disparate inequities in alcohol harm in Aotearoa New Zealand is a breach of Te Tiriti o Waitangi and our human rights. We call on the WHO to protect Maaori and other indigenous people's health.
3. Kookiri Ki Taamakimakaurau Trust thanks you again for this opportunity.

'Te mea nui te reo oo nga iwi taketake'

The voices of indigenous people matter

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

Country/Location: Norway

URL: <https://www.korus-sor.no/>

Submission

It is important to mention alcohol use during pregnancy as one of the harms that must be addressed by the working document. Alcohol use during pregnancy causes brain damage to the unborn child that lasts over the entire life span.

Distribution among living newborns:

* FAS: USA: 0,2-0,7%. South-Africa: 4,1-4,6%

* FASD: USA: 2,0-5,0%. South-Africa: 6,8-8,9%. Italy: 2,3-6,3%.

(Mayet al., 2011; May et al., 2009; May et al., 2007).

Attachment(s): 0

L.K. Advocates

Country/Location: Kenya

Submission

Africa is considered a 3rd world continent, where it is estimated that one in every three people lives below the global poverty line, representing more than the world's 70% poorest people. Due to this fact, it is not the majority of the continents population that consumes alcohol. Poverty overweighs lifestyle, where majority do not have the luxury to choose their lifestyles. Accurate data on deaths is lacking, and therefore the numbers available on the cause of death are not accurate, thus a complication to policy making. Majority of the deaths in the continents are as a result of lack of access to proper health care, and the severe poverty the people experience due to systemic problems that by far expose them to health conditions more than lifestyle choices.

African governments ought to look deeper into the key reasons for the harmful use of alcoholic beverages, and begin by conducting real time extensive research to generate useful data. It is from this standpoint that any sustainable solutions to the problem may be developed. With the high levels of poverty, tax increase and restrictive laws will not achieve the goal of reducing harmful practices. Law reform that is more inclusive of the industry players and local realities focused more of sensitization and education and improvement of health services will go a very long way in the continent.

Attachment(s): 1

00434_69_summary-submission-to-who.pdf

INTRODUCTION

Africa is considered a 3rd world continent, where it is estimated that one in every three people lives below the global poverty line, representing more than the world's 70% poorest people.¹ Due to this fact, it is not the majority of the continents population that consumes alcohol. Poverty overweighs lifestyle, where majority do not have the luxury to choose their lifestyles. Accurate data on deaths is lacking, and therefore the numbers available on the cause of death are not accurate, thus a complication to policy making.² Majority of the deaths in the continents are as a result of lack of access to proper health care, and the severe poverty the people experience due to systemic problems that by far expose them to health conditions more than lifestyle choices.

African governments ought to look deeper into the key reasons for the harmful use of alcoholic beverages, and begin by conducting real time extensive research to generate useful data. It is from this standpoint that any sustainable solutions to the problem may be developed. With the high levels of poverty, tax increase and restrictive laws will not achieve the goal of reducing harmful practices. Law reform that is more inclusive of the industry players and local realities focused more of sensitization and education and improvement of health services will go a very long way in the continent.

The NCD Global Action Plan

The plan lists the harmful use of alcohol as one of four key risk factors for major NCDs. African countries have long been battling with communicable diseases as Malaria, HIV and Tuberculosis, which have been among key contributors of disease burden. Like most low-income countries there is a shift to NCDs increasing the burden to disease.³ The exposure of African people to NCD risk factors need to be researched alongside the cost of healthcare and availability of proper care in the

¹ Brookings, *"Poverty in Africa is falling but not fast enough"*

<<https://www.brookings.edu/blog/future-development/2019/03/28/poverty-in-africa-is-now-falling-but-not-fast-enough/#:~:text=Africa%20is%20the%20world's%20last,of%20the%20world's%20poorest%20people.>>

² WHO, *"What's the cause? Certifying deaths in Africa"*

<<https://www.afro.who.int/news/whats-cause-certifying-deaths-sub-saharan-africa>>

³ The Lancet Global Health, *"Burden of non-communicable diseases in sub-saharan Africa 1990-2017"* <[https://www.thelancet.com/journals/laninf/article/PIIS2214-109X\(19\)30374-2/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS2214-109X(19)30374-2/fulltext)>

region, to allow early detecting and treatment to save life. Harmful use of alcohol is one of the risk factors, but not the only one or said to be the main risk factor of NCDs in Africa. Most of the suffering stems from the poverty levels that force people to expose themselves to harsh environmental and working conditions in search of money for sustenance. We see way more effort and resources targeted towards alcohol use in the global plan for NCDs and not the same level of attention for other risk factors, which together contribute, to the rising cases of NCDs in Africa. The isolation of use of alcohol as the cause of NCD diseases is therefore not an accurate representation of the reality.

Tax Increase on Alcoholic Beverages

Increase in Taxation may be cost effective to the government but a very unfair burden to an already burdened African who is heavily taxed and does not receive government services, even the very basic of them. Education and community sensitization would achieve the goal of communicating the dangers of harmful use of alcohol far more than increased taxation. Taxation is a tool to raise funds for service delivery of government's core services, and should not be used to punish citizens for choosing a lifestyle.

This is discrimination as it forces us into bringing morality and the law into one realm, which they do not belong to. Using taxation as deterrence to the use of alcoholic beverages to stop harmful use, cannot work, because the harmful use is not caused by the mere use of alcoholic beverages. This has been part of our African communities since the beginning of time. It is the bad behavior of some individuals reacting to a challenge in their lives that leads to their harmful use of alcohol. This kind of tax increase is thus a misuse of policy and unfair punishment of people.

Ban on Alcohol Advertising

The main argument for regulations that demand a restriction on marketing of alcoholic beverages has been that children are exposed to this lifestyle, which is harmful to their health. An important question to ask is, what is the power of an advertisement? Is it by itself powerful enough to turn a sober person into an addict? How likely will an advertisement on social media lead to harmful use by the majority of alcoholic beverages? Do the bans on advertising bring intended results of reducing harmful use of alcoholic beverages?

The reality on ground for us in Africa is in the negative. Such restrictive measures hurt the economy far more than they end addictive behaviour or reduce occurrence of NCDs. These companies employ thousands of locals in an already toxic

environment where unemployment is very high, not only at the production companies but also in the retail sector and third party business places, events etc. Parents are directly responsible for what their children are exposed to and it is their job to shield them from harmful substances and behaviors, by first practicing good behavior at home. A well-trained child cannot be easily swayed by an advertisement. Similarly, a well-educated populace on the risks associated with the harmful use of alcohol will be careful and employ prudence in their use of the beverages.

The working paper states that 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. In a continent where communities remain underdeveloped due to lack of proper leadership and continued cases of corruption, cultural practices are not the problem and cannot be blamed for encouraging harmful alcohol consumption practices. Such behavior was not the norm in traditional African societies. Delay in health seeking is not intentional. The available health facilities are many kilometers away and such a struggle to get to, considering also the level of poverty and lack of transport services for those in rural communities. Due to heavy regulation, affordable medicine is very limited, and the private option is far too expensive. Systemic challenges are thus to blame regards delays to seeking health support in Africa.

Restrictions on Physical Availability

If what we are trying to resolve is the harmful use of alcoholic beverages, why punish the majority for the mistakes of a few? Making alcoholic beverages less available, will only result in harmful practices and open up black markets that often go hand in hand with criminal activities and loss of life due to the dangerous trade. In a continent where access to justice is a challenge, and government systems are broken it is questionable on whether the states would have the capacities to deal with the ripple effect of such a move.

Such a regulation would also be targeting the majority who are low income earners as the rich class will be able to afford, and even control the value chains of the alcohol industry. This will in turn end up being a law against the poor, as a discriminative law that speaks of hate of the poor by the government. Such a law would be communicating that the poor ought not to enjoy their lives, and should not make lifestyle choices on their own with the argument that the same is harmful to their health.

Mortality Rates in Africa

The working paper states that the 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.

In their 2016 study, Africa check listed the top causes of death from African countries, with top 5 causes attributed to lower respiratory tract infections, HIV/AIDS, diarrhoeal diseases, malaria and tuberculosis. In their study NCDs are under group two causes of deaths.⁴ While the listing of NCDs could have increased, it is still not among the very top causes for mortality in the continent. Access to health care remains a great challenge in a continent where severe poverty is prevalent and underdeveloped infrastructure. The NCD cases are also often related to other contributory factors, of which harmful use of alcohol may be inclusive, but not the only or main reason for the said infection. Therefore consumption of alcoholic beverages ought not to gain the main focus in tackling the rising cases of NCD cases.

Awareness on Negative Impact of Harmful consumption

African governments have created local institutions to tackle the drug addiction menace, which involves harmful consumption of alcohol. These institutions are funded by taxpayers funds, however they are not seen to do much in educating the populace including using TV, radio and social media on impacts of harmful consumption. There is also no excuse why the same education is not given in colleges, and to senior high school students. We cannot blame the lack of awareness campaigns by governments and other institutions to the commercial messaging. Increasing the regulation of alcoholic beverages achieves stopping that, but does not mean it will result in a shift to messaging harmful effects of alcohol use and risks involved. It is not factual to allege that commercial messaging deprioritize efforts to counter harmful use of alcohol. The market is too large for this outcome, and therefore governments need to be more creative and put in more efforts in educating people of harmful alcohol consumption than in fighting players of the alcohol industry with stringent regulation and high taxes that only end up harming the economy.

⁴ Africa Check, *"Factsheet: Africa's Leading Causes of Death in 2016"*

<<https://africacheck.org/factsheets/factsheet-africas-leading-causes-death/>>

The working paper reports that 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. It is factual to state that informal and illegal production are significantly different in nature and are to be responded to with different sets of policy and government response where necessary. Informal does not necessarily mean illegal, especially In our African setting where informal can be said to be the traditional brews, which have been made and consumed by communities for centuries without said modern day harmful health consequences.

Illicit alcohol production leads to serious health consequences and even loss of life and should be addressed, albeit in isolation from consumption of alcohol. The regulation should not be implemented with a blanket approach to affect all players of the industry for we have seen that consumption of alcoholic beverages does not have the direct result of making one a harmful user. Governments must be careful in drafting policy when protecting the health of its populations, for there is a very thin line between honest protection, and too much control that is discriminative.

Therefore such tough measures, of policing people and restricting access to lifestyle commodities, do not make an impact on harm reduction. A collaborated approach with the alcohol industry players, focus on education of risk factors and sensitization alongside commercial marketing would have a far more practical result.

Latvian Public Health Association

Country/Location: Latvia

URL: <http://lsva.lv/>

Submission

We fully support this very well structured and informative document with a high added value for the practical use in Member States.

Attachment(s): 0

Liberální Institut

Country/Location: Czechia

URL: <http://libinst.cz>

Submission

The World Health Organization's (WHO) push to combat use of alcohol as outlined the new action plan will not succeed. On the contrary, the proposed initiative will result in even more harm, as historical evidence suggests. In this consultation brief, we argue that the proposal is misguided, falls outside the WHO's main mission, and would yield adverse results. We plead with the WHO not go ahead with the plan as currently designed.

Attachment(s): 1

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Summary

The World Health Organization's (WHO) push to combat use of alcohol as outlined the new action plan will not succeed. On the contrary, the proposed initiative will result in even more harm, as historical evidence suggests. In this consultation brief, we argue that the proposal is misguided, falls outside the WHO's main mission, and would yield adverse results. We plead with the WHO not go ahead with the plan as currently designed.

Mission creep

Whereas one of the basic principles spelled out in the first edition of the WHO Constitution (World Health Organization 1946, p. 2), as well as in the current Constitution as amended (World Health Organization 2020a, p. 1), that is “basic to the happiness, harmonious relations and security of all peoples” is the “[u]nequal development in different countries in the promotion of health and control of disease, especially communicable disease, [which] is a common danger”.

This is not to say that this is the sole basic principle but it is the one that we view as essential. And the WHO seems to have viewed it accordingly when we take a look at its laudable history of combatting tuberculosis, malaria, smallpox, polio, or AIDS which are diseases that impact mainly people from under-developed countries.

The WHO's recent push to involve itself in the fight against smoking or against alcohol consumption is something this organization should, in our view, not preoccupy itself with. National governments are well-equipped to deal with these issues if they so choose. The policy is not even targeted at specific countries with high levels of cigarette or alcohol abuse but aims to apply to all Member States.

Moreover, this approach would mostly hurt the least well-off. We consider the adverse effects of this policy to be in direct contradiction to the WHO's basic principles.

Increasing market concentration

The WHO aims for a “relative reduction in alcohol per capita” (World Health Organization 2020b, p. 11) in the next five to ten years by way of – among other things – policies regulating “availability of alcohol”, “marketing of alcoholic beverages”, or “pricing” (World Health Organization 2010, p. 10).

Economic literature¹ is quite clear that this would lead to these effects:

- (i) increased market concentration²
- (ii) higher prices³
- (iii) lower quality⁴

¹ See generally (Mankiw 2017).

² For case studies in market concentration, see e.g. (Mirza 2019), (Eckard 1991), or (Sass and Saurman 1995)

³ Price floors obviously lead to higher prices, we do not need to argue this point further.

⁴ The relationship between market concentration (as established *supra*) and quality holds across diverse markets. See e.g. (Borcherding and Silberberg 1978), (Feng, et al. 2015), (Berry and Waldfogel 2010), or (Mathur 2015).



These would in turn disproportionately affect consumers with little disposable income as the demand for alcoholic beverages is famously non-elastic, see e.g. (Nelson 2013). And as people spend a greater share of their income on consumption goods, they have less money left for goods that might improve their health, e.g. healthier foodstuffs, exercise, therapy, and others. See generally (OECD 2020).

Worryingly, the WHO 2020 Working Document talks about reduction in alcohol use, not *abuse*. We note that not nearly not all alcohol use is abusive and there are many benefits of moderate alcohol use, see e.g. (Baum-Baicker 1985), (Damström Thakker 2006), (Standridge, Zylstra and Adams 2004), or (Peters and Stringham 2006).

We would be remiss not to mention the Orwellian language of the “monitoring and surveillance” area that expressly states: “Local, national and international monitoring and surveillance are needed in order to monitor the magnitude and trends of alcohol related harms, to strengthen advocacy, to formulate policies and to assess impact of interventions. Monitoring should also capture the profile of people accessing services and the reason why people most affected are not accessing prevention and treatment services.” However, we shall develop our arguments against the ever increasing surveillance, as well as free speech, freedom of contract, and other constitutional issues raised by this proposal, in another forum.

Informal and illegal markets

Drinking alcohol has been a cultural and social phenomenon for most cultures on Earth for quite some time. It is not only a thing of the past, it is also a thing of the future since such – in some ways essential – parts of human behavior do not change overnight. This is not an apology for harmful use; it is simply a description of the world as it is. Understanding the true nature of alcohol consumption rather than some version of reality that we would prefer is essential for setting up the right course of actions when we see the need.

Furthermore, as opposed to cigarette regulation, alcohol regulation is always doomed to fail. Whereas tobacco does not grow in everyman’s backyard and home production of cigarettes is therefore rather difficult, informal production of alcohol is easy, well-understood, and very common. For a basic overview, see (Wikipedia 2020).

There is, of course, no need to remind ourselves of the infamous example of the 1920s prohibition in the United States which was full of violence and abuse. This was a result of alcohol-consumption policy gone wrong. Unfortunately, there is more recent story from the Czech Republic from the early 2010s when existing alcohol restrictions led to death of 50 people and permanent damage for many more in an unexpected turn of events (Belackova, et al. 2017). This is not an ancient history; this is still in living memory. What happened?

There were no cruel intentions at the beginning; it was just a coincidence of bad luck and incompetence. One of local low-end spirits producers purchased methanol instead of ethanol to be able to compete with other market participants in terms of prices. The switch from ethanol to methanol had a simple reason – different taxation. The producer’s actions were, of course, illegal, selfish, stupid, that is all true. But it is a behavior we need to count with and we have already mentioned above who bore the price; despite the good intentions in the beginning.



Clearly, the producer did not produce a high quality product to begin with. It was a poor man's drink that was sold across the country and it was the poor who suffered. If there is anyone who needs protection, it is exactly the less fortunate citizens. Yet again, they were the ones who got hurt.

Similar stories are bound to become more frequent with increased unavailability of legal alcohol. People will not stop drinking alcohol and getting intoxicated. Poor consumers will have to switch to illegal drinking of moonshine or substitutes such as technical alcohol and wealthier consumers will replace more expensive drinks with cheaper ones that are often of lower quality. Increased usage of harder drugs in case of prohibitive measures imposed on alcohol consumption is well documented. For a recent example, see (Beletsky and Davis 2017).

The proposed changes in the WHO's position might result in an overall decrease of alcohol consumption in yearly statistics, but this will be outweighed by an increase of informal and illegal alcohol consumption, switching to moonshine, lower quality alcohol, or harder drugs, and most importantly, it will lead to more fatalities. This is certainly not the course of action we would recommend.

All in all, if these measures are aimed at protecting health, they largely fail. An approach tailored much more narrowly is in order.

Respectfully submitted.

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Libertania

Country/Location: North Macedonia

URL: libertania.org

Submission

Taxation, consumption, and substitution

Higher taxation seems to be the key takeaway of the working paper, regarding it as the cure for lowering consumption and in turn lowering harm. However, this couldn't be further from the truth.

Although a change in policy as in increased taxation does indeed bring about lower legal consumption, it breeds behavior change as well. In the extreme case with a complete ban on legal production and consumption as was the case during the roaring twenties in the U.S., production, and consumption does not cease to exist. Even with a policy less extreme, adverse effects are still everywhere to be found.

The production that shifts outside the legal sphere stops adhering to the quality standards, making consumption riskier and costlier. At the same time, people adjust their behavior and spend less on alcohol in the jurisdictions where it is costlier, which brings life to the solutions like the Swedish booze-cruise industry. This way, even if overall consumption is lowered, it is hardly lowered enough, while the jurisdictions with increased taxation are deprived of the necessary healthcare alcohol-related funds, making the whole endeavor less manageable.

The lowering of the relative price disparity between brands due to increased taxation favors the more expensive brands. Should we assume that price and quality correlate, it can be said that there is an overall increase in higher quality consumption in the legal market. Coupled with a relative decrease in consumption due to the increased prices, the busybodies can claim an overall decrease in harm.

Even when we disregard the adverse effects of the particular behavior changes mentioned previously, this overall decrease in consumption is not shared by every group in society. Alcoholics don't suddenly stop drinking when met with an increased price. What they end up with is a negligible decrease in consumption and harm, while at the same time with less money in their pockets to spend on alcohol-related healthcare. Thus, a policy intended to lower the harmful effects of alcohol consumption focuses on lowering the per capita alcohol consumption, equalizing consumption with harm, and not overconsumption. This way, the hurt parties are especially the ones in the 'most need of help'.

Lastly, teenagers don't have much money at their disposal, nor alcohol is legal for them, yet they still drink it. Because the marginal propensity to spend on alcohol rises with higher income, teenagers drink relatively low-quality alcohol. I have done this. My whole generation has done this (at least where I come from). I doubt things are any different today. When met with an increased cost, not because of production but taxation, a "forbidden fruit effect" rises, especially among groups that detest authority. Thus, a policy intended to lower consumption leads the way for the exact opposite effect amongst one of the most vulnerable groups in society.

The solution

People mistrust much of what governments suggest and rightfully so. The damaging dietary guidelines that wreak havoc in the United States in the 1970s, which were never fully adjusted to the latest science had to offer are a perfect example. Alcohol policy, especially through increased taxation is no different. Such a policy will be accepted even less when it comes from an inter-governmental organization that disregards differing cultures in their one-size-fits-all policy suggestion.

Even though smoking was an already accepted custom, many people took up smoking because their favorite Hollywood stars lit up in front of the camera. Much has changed from Hollywood's Golden Age, however, stars are still stars. Just as back then, people will believe Dwayne 'The Rock' Johnson on how to live healthy much more than any governmental or inter-governmental agency.

Conclusion

Alcohol policy, just like any other policy should be in the public interest. When it comes to alcohol or any other 'vice' that is, a tax policy that goes beyond covering the external costs of the consumption of the vice crosses the line where public interest and tyranny meet. Instead of focusing on things that can hardly be controlled or measured, the WHO should focus on changing culture when it comes to alcohol's harmful (over)consumption, and not just consumption itself. Because in C.S. Lewis's words, "of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive."

Attachment(s): 0

Liberty Sparks

Department/Unit: *Research and Academics*

Country/Location: United Republic of Tanzania

URL: www.libertysparks.org

Submission

Already, the alcohol industry today faces relatively many restrictions regarding availability and rules on consumption. Different countries have set a minimum age, opening and closing hours of pubs and liquor shops, various measures in drink and driving through their alcohol regulations which guided by the global strategy to reduce the harmful use of alcohol. In Norway, for instance, to buy wine, the minimum age is 18 years. For spirits, it is 20 years. Beer can be available in most shops but is only sold before 8 pm on weekdays or 6 pm on Saturdays. For wine, spirits or strong beer, one must visit one of the Vinmonopolet outlets, found in most large cities and towns. On setting the scene, the working document for the development of an action plan cites an increased number of countries that have written alcohol policy with Africa and the Americas lagging.

No, much progress happened in 8 years (2010 – 2018), despite many regulations introduced as an option for harm reduction yet the working document, seem to retire all the efforts including its initiative and bring about the new set of strategies that are more harm and limit human choices and doesn't help either developed or developing countries and because of the extreme direct effect of excessive taxation, it would affect the economic stability of countries. While there is room for approach-based change to save foreign investment and world economics.

Attachment(s): 1

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Summary

Already, the alcohol industry today faces relatively many restrictions regarding availability and rules on consumption. Different countries have set a minimum age, opening and closing hours of pubs and liquor shops, various measures in drink and driving through their alcohol regulations which guided by the global strategy to reduce the harmful use of alcohol. In Norway, for instance, to buy wine, the minimum age is 18 years. For spirits, it is 20 years. Beer can be available in most shops but is only sold before 8 pm on weekdays or 6 pm on Saturdays. For wine, spirits or strong beer, one must visit one of the Vinmonopolet outlets, found in most large cities and towns. On setting the scene, the working document for the development of an action plan cites an increased number of countries that have written alcohol policy with Africa and the Americas lagging.

No, much progress happened in 8 years (2010 – 2018), despite many regulations introduced as an option for harm reduction yet the working document, seem to retire all the efforts including its initiative and bring about the new set of strategies that are more harm and limit human choices and doesn't help either developed or developing countries and because of the extreme direct effect of excessive taxation, it would affect the economic stability of countries. While there is room for approach-based change to save foreign investment and world economics.

Strengthening Restrictions on alcohol availability

The Neo-prohibitionist approach influences the market climate as it is a win-lose approach, and the countries should consider the positive economic impact of the alcoholic industry as seen in Alcoholic Worldwide global survey projections before agreeing to anything. The projections show how the alcoholic industry is important for the economic perspective, irrespective of the health consequences for the consumer. It's time for WHO to stop view alcohol in its end-product form. Instead, they should see it's a supply chain with different activities, people, entities and resources. Advocates for strengthening restrictions of alcohol availability should see millions of wheat and barley farmers, manufacturers of fertilizers, the fleet of trucks for supplying resources and distribution, manufacturers of glass bottles and utilities water, electricity, not to mention sewage services.

In 2006, in the European Union (EU), the spirits sector directly employs about 50,000 people and indirectly 250,000 people.²⁴ On the brewing side, the 2,800 European breweries provide jobs for around 164,000 employees and indirectly 2.6 million jobs (comparable to the total workforce of countries such as Slovakia, Finland or Denmark). For each job offered in the brewing sector, it is estimated that one job is generated in retail, two in the supplying sectors and almost twelve in the hospitality sector (ICAP). Only a few other sectors can employ (direct or indirect) a large part of the population or gain the services from other a few in such huge numbers. Any further restriction on the availability of alcohol will affect employment and welfare of the society.

Harm-based approach versus consumption-based approach

The Global Strategy 2020 shares the mysterious reality that harmful alcohol use has a serious effect on public health and is perceived to be one of the key risk factors for poor health worldwide, harmful alcohol use is a substantial contributor to the global burden of disease and is classified as the third leading risk factor for premature deaths and disabilities in the world and other diseases. It's time now for the WHO to have a clear focus and choose whether to reduce the harmful use of alcohol as a strategy to reduce health-related risk or uses of alcohol?

WHO agreed that Informally and illegally production of alcohol amounts to about 25% of total alcohol consumption per capita worldwide, and in some jurisdictions exceeds half all alcohol

consumed by the population. 25% is a lot for health and death related source experience. In Tanzania Traditional alcoholic beverages homemade' or 'informal-sector' drinks: around 2.4 billion litres a year or more. This accounts for 90% of the alcohol consumed in the United Republic of Tanzania. This illicit business has caused death and other disease-related such as kidney failure and cancer that turn to death. In India, a northern state of Punjab 105 people died from poisoning linked to toxic liquor, In Philippines, a town of Rizal in the province of Laguna, southern of Manila 8 people died because of coconut wine that believed to contain high levels of methanol and 300 hospitalized. In Mexico, 35 people died after drinking methanol the latest in a series of mass bad alcohol poisoning after the country banned beer and liquor selling. In particular, according to Nikander, *et al.*, (1992) the health problems related to excessive alcohol consumption in Africa seem to differ from those found in the Western countries. This may be because of yet undiscovered reasons, such as genetic or nutritional factors, impurities in local brews, and consumption of alcoholic beverages containing other pharmacologically harmful and even cancer-causing substances that stand as a reality.

Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion :

The working document mentions alcohol advertising many times. Whereas the 2010 Global Strategy made recommends about the content of alcohol advertising, the working document proposes a total ban however most people view alcohol in its end product form, in a bottle, employing a handful bartenders with little use of the utility. Only a few can see its supply chain with different activities, people, entities and resources.

In 2006, in the European Union (EU), the spirits sector directly employs about 50,000 people and indirectly 250,000 people.²⁴ On the brewing side, the 2,800 European breweries provide jobs for around 164,000 employees and indirectly 2.6 million jobs (comparable to the total workforce of countries such as Slovakia, Finland or Denmark). For each job offered in the brewing sector, it is estimated that one job is generated in retail, two in the supplying sectors and almost twelve in the hospitality sector (ICAP). Only a few other sectors can employ (direct or indirect) a large part of the population or gain the services from other enterprises in such huge numbers. Any further restriction on the availability of alcohol will influence employment and welfare of the society.

The taxes extracted from alcohol retailers and produce are enough to for the state not to intervene in their rights to commercial speech and get rewards for the efforts and their investment in this competitive market. In Tanzania, TBL is paying over 504 Billion Tanzania Shillings as tax apart from social responsibilities that a company is doing. In 2018 the company planted 100,000 trees that cost 100,000 USD as part protecting the environment.

On the users' side, according to the Hannah Ritchie (2018) Alcoholic Worldwide global survey, the market for alcoholic beverages has seen a secular decline in volume sales in developed markets, although demand in developing economies continues to rise yet there is very little evidence that alcohol advertising leads to an increase in alcohol consumption, let alone an increase in harmful consumption. That makes more sense to say the advertising of alcohol is designed to protect and grow market share for individual brands. If advertising aimed to increase the overall size of the market, then it doesn't seem to work very well, Recent analyses of surveys of youth drinking in Sweden have found a strong decrease both in rates of abstinence and in levels of drinking among drinkers ([Raninen, Livingston, & Leifman, 2014](#)). For instance, alcohol consumption among 15- to 16-year-olds has fallen over 50% between 2000 and 2012 ([Norström & Svensson, 2014](#)) Similar declining trends of alcohol consumption among young people have been identified in other European countries, North America and Australia ([De Looze, Raaijmakers, Bogt, & Pickett, 2015](#); [Hibell et al., 2012](#); [Livingston et al., 2016](#)). The reason behind decrease is said to be behaviour change and increase the use of social media despite how much is spent in marketing.

Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion will have adverse effects in the economies and deny opportunities to talents when there no other promising sector to fill the gap. Advertisements on alcohol, particularly, offers more sophisticated and captivating messages more than any other campaigns promoting hard-working such as Tusker a from Kenya. On the other end, many sports and entertainment activities are made possible only through sponsorship from alcohol industries. From Heineken's sponsorship for UEFA Champions League in Europe to Carlsberg's sponsorship for Liverpool Football Club in England or Serengeti Breweries which has sealed three-year sponsorship for Tanzania women's premier league and the national team, the industry is found in all arena of sports. The total ban on the advertisement will have an adverse effect on the economies and deny opportunities to talents when there no other promising sector to fill the gap.

Raise prices on alcohol through excise taxes and other pricing policies.

Alcohol employs people in bars, restaurants and agriculture sector, it brings in foreign currency for exported beverages and generates tax revenues for the government. Raising taxes on alcohol is not the same as raising the government's revenue from alcohol. Therefore, raising the price will hamper economic growth, resulting in job losses and lower wages (Economic Helps). The alcohol tax increases will hurt workers whose livelihoods depend on the production and sale of alcoholic beverages. The tax increase could cause a permanent job loss through employment losses in the alcohol industry will eventually be offset by employment gains in other sectors of the economy (Kenkel and Manning 1996)

A higher price of alcohol can also encourage people to switch to illicit homemade brews, which in several cases is dangerous since leaves people exposed to alcohol of an unknown quantity and composition. It is also a simple way for some outlets to increase their profits. WHO should put much emphasis on raising awareness on responsible and safe drinking rather than increasing to its policies such measures with adverse effects.

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). Regardless of the health effects of the alcoholic industry, however, the Noe-prohibitionist solution should not be explicitly implemented by the Member State as it could, on the one hand, help health consequences and produce burned economic consequences that could take many years for the change. The autonomous state must be left alone to decide where to direct the taxpayers' money. It's not the job of the government nor inter- governments agencies to pressurize supports to pressure groups. The taxpayer's money should solve the needs and problems of the people such as the building of infrastructure for their smoothly exchanging. WHO must put the policy proposal before member state and provide a room for the regimes to add to their manifesto and sell it to their voters during election and not forceful taxes alcohol for third party benefits.

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<https://pubs.niaaa.nih.gov/publications/10report/chap06a.pdf>

Lithuanian Tobacco and Alcohol Control Coalition

Country/Location: Lithuania

URL: www.ntakk.lt

Submission

The document is very welcome and long overdue. A very important improvement could be strengthening the language and action against alcohol and related industry interference. Alcohol industry has a fundamental conflict of interest and gain substantial part of their profits from heavy alcohol use. In the action plan, the alcohol industry should be dealt with in a single paragraph, emphasizing that there is no evidence of any benefit for reducing alcohol related burden through industry self-regulation or corporate social responsibility schemes. It should mention detrimental industry interference impact on democracy, sustainability and public health, contribution to health inequalities. We believe that WHO should not engage in dialogue and promote and help countries to abstain from such dialogue in the area of public health. There should be stronger emphasis on protecting children and young people, by ensuring that they can grow up and live in the environment without alcohol marketing.

Attachment(s): 0

Massey University

Department/Unit: *Social and Health Outcomes Research and Evaluation*

Country/Location: New Zealand

URL: <https://shoreandwhariki.ac.nz/>

Submission

Social and Health Outcomes Research and Evaluation (SHORE)

SHORE & Whariki Research Centre, College of Health

Massey University

New Zealand

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 applaud WHO for the enormous effort taken to prepare this working document. We appreciate the immense challenges in implementation of the Global Strategy, particularly the strong competing interests of the alcohol industry. As a WHO Collaborating Centre, we fully support the working paper's proposed actions for civil society organizations and academia across the six action areas.

1. Promoting the SAFER initiative

We are pleased to note that the WHO-led SAFER initiative incorporating the “best buys” and the “good buys” was included as key to reducing morbidity and mortality due to alcohol use. The three “best buy” interventions,¹ : increasing excise taxes on alcoholic beverages, enacting and enforcing comprehensive restrictions on alcohol marketing, and enacting and enforcing restrictions on the physical availability of alcohol, should form the core focus of the action plan. However, the SAFER interventions were only aligned to a single global target 1.1 under action area 1: implementation of high-impact strategies and interventions.

We suggest that the SAFER interventions, particularly the “best buys”, should be more strongly promoted across all the action areas, and that at a minimum, specific global targets be assigned to each of the SAFER policy options. Per capita alcohol consumption measures are a crucially important overall indicator, along with measures of alcohol harm, but the targets should also include measure of policy uptake and implementation, which are feasible to collect on an annual basis from low- and middle-income countries (LMICs) as well as high-income countries (HICs), and which accurately reflect current status and changes in effective policy.

2. Addressing conflicts of interest

In “setting the scene”, the working paper highlights the need to support the development and implementation of effective policies and actions yet drew little attention to how transnational alcohol companies undermine alcohol control efforts in national settings. Examples of industry strategies include: interfering with the legislative process to prevent the adoption of control measures,^{2,3} questioning the evidence on alcohol-related harms and effectiveness of interventions, and using CSR

activities to build credibility with the public, journalists and policy-makers in order to interfere with effective policy uptake.⁴⁻⁶ Inherent conflicts of interests mean that the alcohol industry, unless subject to regulation, will continue to adopt business strategies which encourage heavy drinking occasions as they rely on these for a significant portion of their sales and profits.⁷

Given this, the action plan should not address the role of the economic operators in the way laid out in the working paper. The approach undertaken in which “economic operators in alcohol and trade” appear to be accorded the same status as other “international partners and non-state actors” is inappropriate. It is in direct conflict with the working paper’s proposed operational principle of “protection from commercial interests”. The framework and some wording in the working paper creates a strong danger that the alcohol industry will use this to legitimise their role in policy development and implementation to the detriment of public health. An implied suggestion of a relationship between WHO and the alcohol industry puts the independence and integrity of WHO’s work in jeopardy.

We suggest that the action plan excludes the economic interests from the action areas on the basis on the inherent conflict of interest and their record of undermining effective policy development.

3. Equity

We strongly support the working document’s recognition of equity as an important value underpinning the development of the global action plan. The working document acknowledges the slow progress in policy development especially in LMICs, where harm per unit of alcohol consumption is greater than in HICs.⁸ There is also evidence for greater experience of alcohol harm among more deprived groups within countries⁹ including marginalised and impoverished communities, and indigenous peoples in colonised countries.^{10,11} We are concerned the structure and content of the action plan does not adequately reflect a focus on equity.

Invitations to member states, civil society and UN agencies, to facilitate a strong voice in alcohol policy development for these groups should be prominent. We note the lack of a substantive focus on alcohol policy in the work of indigenous peoples in the UN context and see this as an important avenue to enrich alcohol policy development. As an example in relation to advocacy by civil society, in Aotearoa, New Zealand, in the context of a treaty between indigenous people and the Crown, indigenous civil society advocates have taken a claim under te Tiriti o Waitangi concerning the disproportionate health loss experienced by Māori and the failure of the Crown to protect Maori from alcohol harm.

The lack of policy implementation in LMICs since the endorsement of the Global strategy is acknowledged, however, there is not sufficient acknowledgment of the role of the business strategies being employed in LMICs by the transnational alcohol corporations (TNACs), including cross-border marketing to consumers and marketing to stakeholders using corporate social responsibility and public-private partnerships. The TNACs’ commercial activity is driving increases in consumption and alcohol harm by recruiting new consumers and normalising alcohol consumption in different contexts and settings.

We suggest that the action plan include invitations to:

Member states to promote adoption of an equity perspective for all alcohol policy development and intervention – including early engagement with those most impacted by alcohol. Addressing inequalities should be a priority in planning, implementation, monitoring and reporting within countries.

Engage in specific actions to increase collaboration between WHO and UN organisations that support human rights, children’s rights and the wellbeing of women and indigenous peoples

WHO Secretariat to support leadership from LMICs in global and regional policy development.

Each area of the Action Plan should include distinct targets for improving equity in alcohol policy advancement and related outcomes for LMICs and, where possible, for disproportionately affected people within countries.

Progress on equity goals should be reported by the Director General of Health to the World Health Assembly (see point 5).

4. Strengthening international research on policy implementation

We appreciate the working paper’s emphasis on production and dissemination of research under action area 5: knowledge production and information systems. More emphasis is required on evaluation and monitoring of the development and implementation of the five policies outlined in SAFER. There is also a need to document industry influence on alcohol policy and this should be part of member states’ data collection as well as (as suggested in the working paper) being a role for civil society and academia.

We suggest the action plan include:

Mechanisms to fully assess the impact of effective alcohol policy options. Data collection tools that allow for international comparative policy analysis focused on the “best buys”, such as the Alcohol Environment Protocol,¹² should be further refined and used to monitor alcohol policy implementation across member states, including LMICs, allowing monitoring of progress over time and comparison between countries..

An invitation to member states to report level and nature of alcohol industry involvement in alcohol policy development

5. Reviewing and reporting of action plan implementation

We are concerned that while an extensive list of global targets, indicators and milestones was proposed, there appeared to be no specific milestones for reviewing and reporting of the action plan’s implementation.

We suggest that the Director General of WHO be requested to report to the World Health Assembly biennially on the progress of implementing the action plan and, given the importance of intergovernmental collaboration to reduce alcohol-related harm, this should include progress on collaboration across international agencies.

6. Using consistent terminology to describe harms of alcohol use

We note that the terms “harmful use of alcohol” and “alcohol-related harms” were both used to describe the harms of alcohol use throughout the working paper. “Harmful use of alcohol” is misleading as evidence shows that there is no safe level of alcohol consumption.¹³

We suggest that the action plan avoid using the term “harmful use of alcohol”.

7. Considering an international legal framework for alcohol control

Compared to tobacco, the alcohol industry has largely escaped scrutiny of its attempts to distort policy making,¹⁴ and there is no regulation of the TNACs and the digital platforms now widely used to market alcohol across borders. WHO’s Framework Convention on Tobacco Control (FCTC) specifically requires Member States to protect public health policies from commercial and other vested interests of the tobacco industry, also laying out clear guidelines for implementation of Article 5.3.¹⁵ It also functions as a normative document which is influential in relation to negotiations to protect effective policies in the context of trade and investment agreements in a way which the non-binding Global strategy document does not.¹⁶

As acknowledged in the working paper, “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”. Such an instrument is essential to adequately protect effective policies from commercial interference.

We suggest the WHO Expert Panel proposed in the working paper has a broader mandate to review the implementation of the Global Strategy and the action plan and to suggest a way forward (in line with the wording adopted by the WHA Decision¹⁷ rather than be constrained by reference to the Global strategy.

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Attachment(s): 0

Mexican National Beer Chamber

Country/Location: Mexico

Submission

Mexican National Beer Chamber

Attachment(s): 1

00374_36_ksq-opiniónsobredocumentoconsumonocivo-oms-v3-10122020.pdf

Ciudad de México a 11 de diciembre de 2020

Organización Mundial de la Salud (OMS)
P R E S E N T E.

Les saludo a nombre de la Cámara Nacional de la Industria de la Cerveza y de la Malta, “Cerveceros de México”, organismo que representa a esta agroindustria desde su creación en 1962. Hago referencia 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 cual está abierto a consulta pública y del que deseamos expresar ciertas preocupaciones.

Esta Cámara Nacional representa y defiende los intereses generales de la agroindustria cervecera y, de acuerdo con la Ley de Cámaras Empresariales y sus Confederaciones, funge como órgano oficial de consulta, interlocución y colaboración de este sector con autoridades gubernamentales en lo que se refiere al diseño y ejecución de políticas públicas, legislación y normatividad. A la par, impulsa decididamente una agenda de responsabilidad social en colaboración con otros organismos e instituciones públicas, privadas y de sociedad civil con el fin de crear cambios significativos en la comunidad.

Orgullosamente México es líder mundial en producción de cerveza, ocupando el cuarto lugar; así como el primer exportador de cerveza del mundo, representando el 25% de las exportaciones agroindustriales del país y llegando a más de 180 países con marcas mexicanas que orgullosamente muestran ese México nuevo, innovador y pujante.

Cabe señalar que nuestra cadena de valor, amplia e integrada, va desde la cosecha de cebada en el campo, la elaboración de malta y cerveza en planta, así como la distribución y comercialización en puntos de venta. Es a través de esta cadena de valor que la agroindustria cervecera genera 55 mil empleos directos y 600 mil indirectos, incluyendo a más de 5 mil familias de agricultores mexicanos dedicados a la producción de cebada maltera.

Respecto al documento de trabajo referido en el primer párrafo, nos permitimos compartir algunos puntos que podrían fortalecer la implementación de la Estrategia Global:

- **Primero. El Documento de Trabajo señala que existe un conflicto de interés inherente entre la industria del alcohol y la salud pública, lo que justificaría la exclusión de la industria de las discusiones**
 - o La industria cervecera ha colaborado y lo seguirá haciendo con las distintas instancias de gobierno y de sociedad civil en iniciativas, programas piloto, campañas para la reducción del consumo nocivo de alcohol, **promoviendo el consumo responsable.**
 - o En La Industria Cervecera estamos enfocados en ir más allá de las campañas de "concientización", para impulsar un cambio real en las comunidades donde vivimos y trabajamos, a través de intervenciones basadas en la evidencia que se miden y evalúan en el tiempo para probar su efectividad.
 - o Las innovaciones en productos, tales como las cervezas de bajo contenido o sin alcohol (low-no alcohol) también promueven opciones responsables para los consumidores, todo alineado con el objetivo de salud pública por reducir el consumo nocivo de alcohol.
 - o En razón de lo anterior, se enfatiza que no existe tal conflicto entre los intereses de la industria cervecera y los del Sector Público, por lo que los cerveceros solicitamos ser incorporados y tener un lugar en las discusiones de salud pública.
- **Segundo. El Documento de Trabajo no hace una diferenciación entre bebidas alcohólicas de baja (cerveza y fermentados) y alta graduación alcohólica (destilados).**
 - o La diferenciación representa una oportunidad en varios sentidos:

1. Al respecto debe señalarse que los efectos del consumo del alcohol dependen de lo que tomes y cómo lo tomes.
 2. Los efectos del consumo de alcohol dependerán del tipo de bebida que se ingiere. No es lo mismo una cerveza, promedio 4.5% abv, a un destilado con promedio de 38% abv. Es decir, a mayor concentración de alcohol conduce a mayores niveles de intoxicación.
 3. Las políticas deberían orientar a los consumidores hacia bebidas de bajo contenido alcohólico ya que la evidencia señala que estas bebidas se correlacionan en menor medida con las formas nocivas de consumo, en sentido opuesto el consumo rápido de bebidas con alta concentración de alcohol genera un riesgo con efectos como el envenenamiento y accidentes.
 4. Incentivar la innovación en los procesos de producción para el desarrollo de productos de bajo contenido o sin alcohol como lo hemos impulsado desde la industria cervecera en los últimos años.
- El tipo de bebida y los patrones de consumo influyen en los resultados de salud a nivel de la población de maneras que aún no están completamente integradas en las evaluaciones de riesgos globales o en las recomendaciones de políticas formales de la Estrategia Global.
 - El plan de acción de la Estrategia Global representa una oportunidad para alinearse con la evidencia actual y proponer políticas que empujen a los consumidores por diseño y no por accidente.
 - La evidencia científica, que se está incorporando cada vez más en las políticas nacionales y regionales sobre el alcohol, también demuestra que dirigir a los consumidores hacia productos con bajo contenido de alcohol puede reducir los daños relacionados con el alcohol.
- **Tercero. El Documento de Trabajo identifica el consumo de alcohol ilícito como un reto, aunque sin presentar vías para su combate.**
- La evidencia científica señala que el mercado ilícito se concentra en las bebidas de alto contenido alcohólico (destiladas). Estudios estiman que el mercado informal, que va la adulteración y el contrabando hasta la evasión de impuestos, representa más de 35% del total de las bebidas destiladas, lo que implica miles de millones en pérdida recaudatoria.
 - Otros estudios señalan que el consumo de bebidas ilegales en un lapso de 5 años (2012 a 2017) se redujo en más de 9 puntos; se estima que el consumo ilegal ha migrado a bebidas legales, pero de bajo precio, especialmente a bebidas destiladas y cervezas, éstas últimas con la menor graduación alcohólica de entre el mercado de bebidas alcohólicas.
 - Ejemplos como el de Rusia, demuestran cómo la tendencia hacia bebidas de menor contenido alcohólico ayuda a reducir los daños de salud pública, así como la magnitud de los mercados ilícitos.
 - Este tipo de mejores prácticas basadas en evidencia, que buscan influir en el consumidor para que se oriente hacia el consumo de bebidas con menor graduación alcohólica, se sugiere sean incorporadas a la **Estrategia Global para reducir el uso nocivo de alcohol**

Agradeciendo de antemano su consideración, creemos firmemente que el desarrollo de política pública responsable y eficiente se ve fortalecida con la cooperación interinstitucional.

Sin más por el momento, me despido y quedo a la orden.

ATENTAMENTE,

KARLA SIQUEIROS ROJO
DIRECTORA GENERAL
CÁMARA NACIONAL DE LA INDUSTRIA DE LA CERVEZA
Y DE LA MALTA "CERVECEROS DE MÉXICO"

Ministerio de Salud de la Nación Argentina

Department/Unit: *Dirección Nacional de abordaje integral de enfermedades no trasmisibles*

Country/Location: Argentina

Submission

El documento ha sido leído y considero que es claro y preciso en cuanto a las estrategias, metas e indicadores presentados para reducir el uso nocivo de alcohol. No añado ningún comentario, salvo que este abordaje, centrado en las estrategias de promoción y prevención, para regular entornos y productos a fin de prohibir el acceso especialmente de los menores de edad al alcohol, así como el manejo intersectorial para la puesta en marcha de políticas poblacionales y el manejo de los conflictos de interés de la industria de alcohol y su potencial interferencia en el diseño de las políticas, constituye un eje de trabajo que a nivel internacional se aborda mayormente desde la estrategia de prevención y promoción de las enfermedades no transmisibles (ENT) dado que comparte similitudes con los otros factores de riesgo de las ENT, tanto en la problemática epidemiológica, como en las estrategias de sus fabricantes, como en las políticas sanitarias que se implementan para dar respuesta. En la Argentina esto sucede desde el año 2019, pero en la mayoría de los países aún existe un abordaje tradicional, necesario pero no suficiente, del alcoholismo, y de esta forma solo trabajado por las Direcciones de Salud Mental. El abordaje desde las ENT es esencial junto con la articulación con Salud Mental en lo que se trata de uno de los estándares asociados a la atención, detección precoz y tratamiento oportuno.

Attachment(s): 0

Ministerio de Salud Pública

Department/Unit: *Departamento de Salud Mental*

Country/Location: Dominican Republic

URL: www.ministeriodesalud.gob.do

Submission

Estamos de acuerdo con los lineamientos que plantea la Estrategia Global para reducción del uso nocivo de alcohol

Consideramos:

Que nuestro país no cuenta en la actualidad con una ley que regule la publicidad del consumo de alcohol en los diferentes medios de comunicación, haciéndose más visibles en las transmisiones de evento deportivos y culturales.

Vista esta situación el Ministerio de Salud Pública a través del del departamento de salud mental ha elaborado un documento técnico para la regulación del contenido de la publicidad de alcohol. Actualmente será llevado a vistas públicas para su aprobación.

Facilidad para adquirir las bebidas alcohólicas en los distintos centros de expendios, convirtiéndose este, en otro factor de riesgo para nuestra población infanto juvenil que, aunque existe el código para el sistema de Protección y los Derechos Fundamentales de Niños, Niñas y Adolescentes, la misma no se aplica con la rigurosidad que se debería, convirtiéndose esto en un problema de Salud Pública ya que la edad de inicio en el consumo de alcohol en República Dominicana es muy temprano.

De acuerdo a un estudio realizado en el Hospital Infantil Robert Reid Cabral en el año 2018 se encontraron cardiopatías congénitas en madres que estuvieron expuestas al consumo nocivo de alcohol lo que viene a reforzar lo expuesto en párrafos anteriores.

El país cuenta con la ley 42-01 que es la Ley General de Salud, la Ley 63-17 Movilidad, Transporte Terrestre, Transito y Seguridad Vial de la República Dominicana y la ley 136-03 Código para el Sistema de Protección y los Derechos Fundamentales de Niños, Niñas y Adolescentes. Que constituyen el marco legal de las políticas de protección ciudadana en República Dominicana

Attachment(s): 1

00344_19_plan-de-acción-finalizado.pdf

ministerio de salud y proteccion social

Department/Unit: *direccion de promocion y prevencion*

Country/Location: Colombia

Submission

Análisis documento de trabajo plan de acción global de reducción del consumo de alcohol 2022 – 2030

Resumen

El desarrollo de un plan de acción (2022-2030) fue solicitado por la decisión del Consejo Ejecutivo de la OMS de aplicar la Estrategia Mundial como prioridad de salud pública. Al respaldar la Estrategia mundial en 2010, la Asamblea Mundial de la Salud afirmó que su objetivo es orientar la acción a todos los niveles y establecer áreas prioritarias para acción.

El objetivo del plan de acción es impulsar la implementación efectiva de la Estrategia Global 2010 como público prioridad sanitaria y reducir considerablemente la morbilidad y la mortalidad debidas al consumo de alcohol, sobre y por encima de las tendencias generales de morbilidad y mortalidad, así como de las consecuencias sociales asociadas

Los objetivos operativos del plan de acción se centran en:

- Incrementar la cobertura de la población y la implementación de opciones de políticas de alto impacto e intervenciones para reducir el consumo nocivo de alcohol en todo el mundo para mejorar la salud y el bienestar.
- Fortalecer la acción multisectorial mediante una gobernanza eficaz y una mejora compromiso y liderazgo, diálogo y coordinación de la acción multisectorial.
- Mejorar la capacidad de prevención y tratamiento de los sistemas de atención sanitaria y social para los trastornos. debido al consumo de alcohol y las condiciones de salud asociadas como parte integral de la salud universal cobertura y alineados con la Agenda 2030 para el Desarrollo Sostenible y su salud objetivos.
- Sensibilizar sobre los riesgos y daños asociados al consumo de alcohol en todos los niveles, así como de la eficacia de las diferentes opciones de políticas para reducir el consumo y daño.
- Fortalecer los sistemas de información y la investigación para monitorear el consumo de alcohol. Daños relacionados con el alcohol y respuestas políticas a todos los niveles con difusión y aplicación. de información con fines de promoción, desarrollo de políticas y evaluación.
- Aumentar significativamente la movilización de recursos necesarios para una adecuada y sostenida acción para reducir el uso nocivo de alcohol a todos los niveles

Para lograr la meta y los objetivos antes mencionados, se proponen las siguientes áreas clave para acción de los Estados Miembros, la Secretaría de la OMS, los socios internacionales y nacionales y, como apropiado, otras partes interesadas:

- Área de acción 1: Implementación de estrategias e intervenciones de alto impacto, Estrategia SAFER

- Área de acción 2: Promoción, sensibilización y compromiso
- Área de acción 3: Asociación, diálogo y coordinación
- Área de acción 4: Apoyo técnico y creación de capacidad
- Área de acción 5: Producción de conocimiento y sistemas de información
- Área de acción 6: Movilización de recursos.

Después de realizar la revisión técnica del documento construido por la OMS se realizan las siguientes apreciaciones

- Se reconoce el valor del documento y lo establecido por la OMS respecto a este documento en cuanto a impulsar de una manera más decidida lo establecido por la estrategia mundial de reducción del consumo de alcohol 2010, afianzado a través del plan global los propósitos de esta y basándose en la evidencia respecto a los efectos que este consumo tiene en términos de salud pública.
- Se valora el esfuerzo de la OMS por colocar la discusión del consumo de alcohol, como una de las principales amenazas que se tiene para alcanzar los objetivos de desarrollo sostenible, lo cual le da una perspectiva amplia y multisectorial a los asuntos y las acciones de alto nivel que se requieren llevar a cabo para transformar las prácticas asociadas al consumo de estas sustancias, lo cual se refleje en menores cifras de consumo y de los impactos que tiene en diversas áreas como la salud, las familias, la económica y la sociedad en su conjunto.
- Colombia como parte del sistema de Naciones Unidas, y teniendo en cuenta en lo establecido en la resolución de la 61.ª Asamblea Mundial de la Salud, ha realizado en el año 2016 la adaptación de la estrategia mundial a una estrategia nacional que fue incorporada en los planes de drogas territoriales para el periodo 2016 – 2020. Actualmente esta estrategia se encuentra en proceso de actualización, en lo que tiene que ver con normatividad en políticas de salud mental y prevención y atención al consumo de sustancias psicoactivas, comportamiento de consumo de sustancias psicoactivas en el contexto nacional, así como en la incorporación en las 10 esferas de acción lo establecido por el paquete de medidas más costo efectivas para avanzar en la reducción del consumo de alcohol SAFER (por sus siglas en inglés)
- A nivel normativo Colombia cuenta en los últimos años con un desarrollo amplio, a partir del cual se requiere redoblar los esfuerzos para su cumplimiento y ampliación con perspectiva de salud pública, entre las normas principales se encuentra
 - o Ley 1566 de 2012, “por la cual se dictan las normas para garantizar la atención integral a personas que consumen sustancias psicoactivas y se crea el premio nacional a la entidad comprometida con la prevención del consumo, abuso y adicción a sustancias psicoactivas”,
 - o Ley 1616 de 2013, mediante la cual “se expide la ley de salud mental y se dictan otras disposiciones”, definió en su artículo 8, que “El Ministerio de Salud y Protección Social dirigirá las acciones de promoción en salud mental a afectar positivamente los determinantes de la salud mental que involucran: inclusión social, eliminación del estigma y la discriminación, buen trato y prevención de las violencias, las prácticas de hostigamiento, acoso o matoneo escolar, prevención del suicidio, prevención del consumo de sustancias psicoactivas...”.

- o Resolución 089 de 2019, mediante la cual se adoptó la Política Integral para la Prevención y Atención del Consumo de Sustancias Psicoactivas, cuyo objetivo central es garantizar la atención integral de las personas con riesgos o consumo problemático de sustancias psicoactivas, familias y comunidades, mediante respuestas programáticas, continuas y efectivas en su reconocimiento como sujetos de derechos, con lo cual se mejore la calidad de vida y bienestar de las personas, familias y comunidades afectadas por el consumo de sustancias psicoactivas, desde una agenda pública nacional y territorial sostenible en el tiempo, garantista del derecho a la salud, en interdependencia de otros derechos..
- o Ley 124 de 1994 por la cual se prohíbe el expendio de bebidas embriagantes a menores de edad;
- o Ley 1385 de 2010, por medio de la cual “se establecen acciones para prevenir el síndrome de alcoholismo fetal en los bebés por el consumo de alcohol de las mujeres en estado de embarazo, y se dictan otras disposiciones”, establece las orientaciones para la implementación de programas tendientes a la prevención y atención de las personas con síndrome alcohólico fetal y el levantamiento de una línea de base que permita monitorear de manera permanente la población y las intervenciones que en el marco del sistema de salud y a nivel intersectorial se desarrollen con ellas.
- o Ley 1696 de 2013, dicta disposiciones penales y administrativas para sancionar la conducción bajo el influjo del alcohol u otras sustancias psicoactivas;
- o Ley 1816 de 2016 en el Artículo 37 define la implementación de programas de prevención y tratamiento por consumo de bebidas alcohólicas.
- o Decreto 120 de 2010, recogido por el decreto 780 de 2016 (decreto único del sector salud) , se resalta la creación la comisión Intersectorial para el control del consumo nocivo de alcohol y el establecimiento de las políticas para el control del consumo de bebidas alcohólicas; y
- o Decreto 1686 de 2012 que realiza la reglamentación relacionada con la fabricación, elaboración, hidratación, envase, almacenamiento, distribución, transporte, comercialización, expendio, exportación e importación de bebidas alcohólicas destinadas para consumo humano.
- Colombia reconoce la importancia de aumentar conciencia mundial sobre la magnitud y la naturaleza de los problemas sanitarios, sociales y económicos. problemas causados por el uso nocivo del alcohol y un mayor compromiso de los gobiernos para actuar abordar el uso nocivo del alcohol, con base en el aumento de los conocimientos y las alianzas con centros educativos, universidades y centros de pensamiento que permitan dimensionar cada vez más, la magnitud y los determinantes de los daños relacionados con el alcohol y, sobre todo, lo relacionado con las intervenciones efectivas para reducir y prevenir tales daños.
- Colombia igualmente reconoce la necesidad de redoblar esfuerzos en lo que tiene que ver con mayor capacidad de los Estados miembros para prevenir la el uso nocivo de alcohol y el manejo de los trastornos por consumo de alcohol y las condiciones de salud asociadas, es así como en el marco de lo establecido por el sistema de salud colombiano, se tienen incorporadas las acciones acorde con la evidencia para la atención integral de las personas que consumen sustancias psicoactivas, incluyendo el consumo de alcohol, desde los procesos de detección temprana e intervenciones breves hasta las acciones de tratamiento acorde con la situación de la persona.

- Así mismo se resalta dentro de los enfoques propuesto lo relacionado con el enfoque de curso de vida, el cual es estructural en el diseño de las respuesta de política que Colombia ha venido emitiendo, a partir del reconocimiento de las particularidades que tiene cada uno de los momentos del curso, los efectos acumulativos que tiene las experiencias vividas en cada uno de ellos y los efectos diferenciales que tiene el consumo de alcohol, con especial énfasis en niños, niñas, jóvenes y adolescentes.
- Se sugiere que el plan de acción global reconozca de una manera mas explícita y oriente los países miembros sobre las estrategias y la forma como se puede proteger la construcción de las políticas públicas de la interferencia de las industrias de las bebidas alcohólicas, en el marco de los documentos contruidos al respecto pro parte de la misma OMS y organizaciones de la sociedad civil tales como la NCD Alliance y global alcohol policy Alliance, bajo el precepto de la protección de los asuntos de la salud pública y por ende la vida de las personas
- Se reconoce así mismo la importancia de la creación de un día mundial de sensibilización sobre los efectos del consumo de alcohol, el cual sirva como momento de reflexión y acción colectiva desde todos los sectores frente a las responsabilidades y proceso que se deben llevar a cabo para disminuir el impacto que en las personas, familias y comunidades tiene esta sustancia.

Respecto al área de acción 1 Implementación de estrategias de alto impacto e intervenciones

- Las responsabilidades de los estados miembros, la secretaria de la OMS y socios internacionales y actores no estatales, son clara y están en el marco de las competencias, en específico de los estados como tal.
- Se sugiere que se especifique de manera más operativa la forma como los estados miembros pueden realizar la adopción de las medidas definidas en el paquete SAFER, esto podría darse colocando un paso a paso sobre como desarrollar de forma general las acciones establecidas para cada uno de los actores, de tal manera que cada país pueda hacer una adaptación mas precisa acorde con su contexto.

En lo que tiene que ver con la acción 2 Promoción, sensibilización y compromiso

- Como se mencionó Colombia cuenta con un marco normativo y político amplio al respecto que requiere ser fortalecido, se está actualizando la estrategia nacional de reducción del consumo de alcohol y se ha venido en el marco de la emergencia sanitaria por COVID 19 generando una discusión en el contexto territorial alrededor de los efectos del consumo de alcohol en la población a través de documentos técnicos emitidos por el Ministerio de Salud y Protección Social
- Al igual que en la acción anterior, generar una serie de pasos a través de los cuales se puede avanzar en los países en establecimiento de políticas regulatorias mas fuertes basadas en el principio de la salud pública, sin desconocer el desarrollo de las empresas que producen bebidas alcohólicas, en aspectos tales como la distribución, la publicidad, mercadeo y patrocinio y en temas como políticas selectivas de precios e impuestos, que sirvan de soporte para las discusiones nacionales en estos temas que pueden ser difíciles de sostener por la interferencia de la industria en las mismas.
- Generar pautas sobre cómo manejar la concientización de los impactos del consumo de alcohol en plataformas virtuales, redes sociales, juegos y APS, lo cual no es tan claro en la estrategia mundial y que en el escenario actual es un aspecto clave de trabajo dado la proliferación de este tipo de

mecanismos de mercadeo de las bebidas alcohólicas y que dado las dificultades del control de los estados de las ismas, requieren de un trabajo sostenido que involucre actores estatales de la sociedad civil medios de comunicación e información y plataforma para garantizar un manejo más armónico con los principios propios de la salud pública.

- Respecto a la acción “medidas adecuadas de protección del consumidor mediante el desarrollo y la implementación de requisitos de etiquetado para bebidas alcohólicas que contienen información esencial sobre los ingredientes, valor calórico y advertencias sanitarias.” Colombia cuenta con una norma al respecto, sin embargo, al igual que lo mencionado anteriormente, es necesario fortalecer las medidas al respecto que incluyan por ejemplo los ingredientes y valor calórico de las bebidas alcohólicas, por lo cual, y en el contexto de lo que se tiene en el mundo al respecto, se sugiere que se puedan definir en este plan medidas mas precisas sobre como los países pueden avanzar al respecto.

Con relación a la acción 3 Asociación, diálogo y coordinación

- En el marco de lo ya expuesto, resaltar la forma como se puede proteger en la medida de lo posible a los estados miembros respecto a la interferencia de la industria en las decisiones para proteger a la población nacional frente al consumo de bebidas alcohólicas,

Respecto a la acción 4 Apoyo técnico y creación de capacidad

- Se considera esta acción como fundamental teniendo en cuenta que se requiere aumentar las capacidades de los equipos técnicos nacionales y subnacionales tanto sectoriales de salud, como de otros sectores, para la implementación de las medidas necesarias para reducir el consumo de alcohol
- Se sugiere que se contemple desde la secretaria técnica de la OMS el diseño de propuestas curriculares de formación para los equipos técnicos que trabajan en los temas, con contenidos y conceptos técnicos mínimos que permitan la implementación de lo definido en la estrategia mundial y plan de acción global y que pueda ser reforzado por las características propias de cada uno de los estados miembros.
- Respecto a esta acción, Colombia en el marco de lo establecido por la ley 1566 de 2012, cuenta con el premio nacional entidades comprometidas con la prevención del consumo de sustancias psicoactivas, incluyendo el consumo de alcohol, que busca reconocer los esfuerzos de entidades públicas, privadas, instituciones educativas y la sociedad civil en la prevención del consumo.

Con relación a la acción 5 Producción de conocimiento y sistemas de información y la acción 6 Movilización de recursos, no se tienen comentarios específicos, dado que los mismos se encuentren contenidos en los ya mencionados.

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Attachment(s): 0

Ministry of Health (Spain)

Department/Unit: *Prevention Area. GS Health Promotion, Prevention and Quality. DG Public Health*

Country/Location: Spain

URL:

<https://www.mscbs.gob.es/profesionales/saludPublica/prevPromocion/Prevencion/alcohol/home.htm>

Submission

First of all, we would like to thank WHO for the opportunity to participate in this relevant consultation. We consider the document to be a crucial starting point for the development of the action plan. Please find attached a document with the main comments of the DG Public Health of the Spanish Ministry of health. A summary of the comments and suggestions:

- Include a specific action on the development of a legally binding international instrument.
- Regarding the nomenclature and definitions of alcohol-related terms:
 - o Remove the mention of “harmful alcohol consumption” replacing it by “alcohol consumption” in general.
 - o Update the Lexicon of alcohol and drug terms published by the World Health Organization, especially some terms (“moderate consumption,” “cautious drinking,” “social drinking,” or “responsible drinking”) which are ambiguous or confusing.
- Mention that cultural or social norms are modifiable, and it is necessary including actions about this.
- Elaborate monographic reports by key sector – evidence based.
- Support the importance of using social media to change the relationship with alcohol
- Highlight in more detail, the relationship between alcohol and inequities and its relationship with other SDG
- Define the role of the economic operators excluding the dialogue with them in the participation on regulatory, legislative and policy-making or health promotion

Attachment(s): 1

00185_16_working-doc-action-plan-global-strategy-to-reduce-alcohol-spain.pdf



Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

First of all, we would like to thank WHO for the opportunity to participate in this relevant consultation. We consider the document to be a crucial starting point for the development of the action plan.

Below, we describe some comments and ideas for consideration:

- 1) We strongly call to **include a specific action on the development of a legally binding international instrument**, modelled on the WHO Framework Convention on Tobacco Control (FCTC). The FCTC has demonstrated to be an important public health instrument and has acted as a strong catalyst and framework for national actions and it can be seen remarkable progress in global tobacco control¹. As indicated in page 4, alcohol remains the only substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments.
 - This common framework is necessary to support member states to protect public health-oriented policy-making from the interference of the alcohol industry. In order to set the “best buys” in alcohol control promoted by SAFER, especially to strength restrictions on alcohol availability and enforce restrictions on alcohol advertising, sponsorship and promotion across national borders and regarding remote selling (online).
 - This action could be included in Action area 1: Proposed actions for the WHO Secretariat. 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.
- 2) Concerning to Action area 2: Proposed actions for the WHO Secretariat. 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.

¹ P Puska. WHO FCTC as a Pioneering and Learning Instrument. Comment on "The Legal Strength of International Health Instruments - What It Brings to Global Health Governance?". Int J Health Policy Manag. 2018 Jan; 7(1): 75–77. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5745870/>



- **We advocate for removing the mention of “harmful alcohol consumption”** replacing it by “alcohol consumption” in general.
 - Taking into account that for certain cancers, gastrointestinal diseases, and injuries, there is no safe consumption level², and not to drink alcohol is the only way of avoiding alcohol-related risks^{3,4}.
 - Harmful alcohol consumption must be used only as its meaning in the Lexicon of alcohol and drug terms published by the World Health Organization⁵. The fact that “harmful use” is only used to describe “alcohol use” and not other main contributors to the four most prominent non-communicable diseases, may imply that alcohol use can be safe and beneficial⁶.
- **It would be recommendable to review this Lexicon and other terms used to adapt them to the new evidence. For example, “moderate consumption,” “cautious drinking,” “social drinking,” or “responsible drinking” which are ambiguous or, confusing terms.**
 - They fail to quantify alcohol intake objectively.
 - These terms are preferably used by different communication media, industry, and some international organisms. Avoiding to specify the amounts allows for subjective extrapolation of what is responsible or moderate for each individual, causing confusion. Therefore, defining alcohol consumption patterns in a quantitative manner will avoid using those terms. For this issue, it would be useful the use of “Low-risk drinking” guidelines as a public health tool⁷.

² Shield KD, Gmel G, Gmel G, Mäkelä P, Probst C, Room R, et al. Life-time risk of mortality due to different levels of alcohol consumption in seven European countries: implications for low-risk drinking guidelines. *Addiction* 2017;112(9):1535-44.

³ European Code Against Cancer [Internet]. WHO International Agency Res. Cancer [citado 2020 jun 20]. Disponible en: <https://cancer-code-europe.iarc.fr/index.php/en/>

⁴ Scoccianti C, Cecchini M, Anderson AS, Berrino F, Boutron-Ruault M-C, Espina C, et al. European Code against Cancer 4th Edition: Alcohol drinking and cancer. *Cancer Epidemiol* 2015;39 Suppl 1:S67-74.

⁵ Lexicon of alcohol and drug terms published by the World Health Organization

https://www.who.int/substance_abuse/terminology/who_lexicon/en/

harmful use (F1x..I) A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use. The term was introduced in ICD-10 and supplanted “non-dependent use” as a diagnostic term. The closest equivalent in other diagnostic systems (e.g. DSM-III-R) is substance abuse, which usually includes social consequences. See also: hazardous use

⁶ Shiu Lun Au Yeung, Tai Hing Lam. Unite for a Framework Convention for Alcohol Control. *The Lancet*, Vol 393 May 4, 2019. Published Online April 4, 2019. [http://dx.doi.org/10.1016/S0140-6736\(18\)32214-1](http://dx.doi.org/10.1016/S0140-6736(18)32214-1) [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)32214-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32214-1/fulltext)

⁷ Good practice principles for low risk drinking guidelines. Editors: Montonen M., Mäkelä P., Scafato E. & Gandin C. on behalf of Joint Action RARHA’s Work. Package 5 working group. Author (s): Broholm K., Galluzzo L., Gandin C., Ghirini S., Ghiselli A., Jones L., Martire S., Mongan D., Montonen M., Mäkelä P., Rossi L., Sarrazin D., Scafato E., Schumacher J., Steffens R. Date: October 2016. Publisher:



- 3) On page 4, **regarding the cultural or social norms, it would be important to mention that these norms can be modified.** Alcohol consumption has historically been considered an intrinsic part of the Spanish culture and strongly associated with Spanish traditions and festivities strengthening the idea that “the normal thing” is to drink and, thus, “it cannot be that bad.” However, it is important to highlight that behaviors- including health-related - are learned, spread, and modified by the environment surrounding the individual (e.g., leisure, advertisement, access). Thus, acting upon these mechanisms which shape this learning process is key to preventing alcohol consumption⁸.
- 4) It would be **very interesting that WHO coordinates the elaboration of monographic reports by key sector** – evidence based. To **mobilize different stakeholders** it is necessary to elaborate specific messages for them, particularly to other government sectors, some of which have competitive interests to public health ones. Relevant sectors are: finances (taxes), commerce (advertising and availability), agriculture, industry, environment, economy, tourism, etc. Informing about the risks and consequences of the alcohol consumption, and how their respective sectors may contribute to alleviating these effects and remarking the benefits for each sector about the reduction of alcohol consumption and its negatives consequences.
- 5) On page 6 it is mentioned that **social media must be used to change the relationship with alcohol.** We agree that it is a very important issue. Thus, it is necessary to use the same channels as the industry does – in the marketing campaigns - in order to sensitize the population on the risks of drinking alcohol, especially in young people.
- 6) It would be necessary to **highlight in more detail the relationship between alcohol and inequities** (Action 5, WHO action 7) and its **relationship with other Sustainable Development Goals** (SDG)⁹ (Action 2. WHO. Action 1. Action area 3.MS. Action 1), because they are only slightly mentioned.
- 7) It would be relevant to **define the role of the economic operators excluding the dialogue with them in the participation on regulatory, legislative and policy-making or health promotion.** The interest of the industry and the public health ones regarding alcohol consumption are opposed. The Second report of the WHO Expert committee on problems related to alcohol consumption (2007) stated that allowing self-regulation by industry

National Institute for Health and Welfare (THL). ISBN 978-952-302-733-6; 978-952-302-734-3 (pdf). <http://urn.fi/URN:ISBN:978-952-302-734-3>

⁸ Ministerio de Sanidad. Límites de Consumo de Bajo Riesgo de Alcohol. Actualización del riesgo relacionado con los niveles de consumo de alcohol, el patrón de consumo y el tipo de bebida . Madrid; 2020. (Available in English soon) https://www.mscbs.gob.es/profesionales/saludPublica/prevPromocion/alcohol/docs/Limites_Consumo_Bajo_Riesgo_Alcohol_Actualizacion.pdf

⁹ In example: http://iogt.org/wp-content/uploads/2015/03/Alcohol-and-SDGs_new.pdf



results in loss of policy control of the marketing of a product that seriously affects public health¹⁰.

A specific framework or guide could be developed in order to establish the terms on which relationships can be established with transparency.

This idea can be incorporated in the Actions were the economic operators are included:

- Action area 1. Proposed actions for international partners and non-State actors.
Action 3.
- Action area 2. Proposed actions for international partners and non-State actors.
Action 3
- Action area 3. Proposed actions for international partners and non-State actors.
Action 6
- Action area 4. Proposed actions for international partners and non-State actors.
Action 3
- Action area 5. Proposed actions for international partners and non-State actors.
Action 6
- Action area 6. Proposed actions for international partners and non-State actors.
Action 3

Madrid, 04/12/2020

¹⁰ Second report / WHO Expert Committee on Problems Related to Alcohol Consumption. (WHO technical report series; no. 944) "WHO Expert Committee on Problems Related to Alcohol Consumption, Geneva, 10–13 October 2006". 2007. Available at: https://www.who.int/substance_abuse/expert_committee_alcohol_trs944.pdf

Ministry of Health

Department/Unit: *Tobacco and Drug Control Department*

Country/Location: Turkey

Submission

We don't have any additional comment and suggestion as Turkey has been achieving almost all the components comprehensively of the mentioned action plan.

On the other hand, to achieve a better and sustainable alcohol control policies and programme an international framework agreement is essential protecting these policies from commercial and other vested interests of the alcohol industry in accordance with national law.

Attachment(s): 0

Ministry of Health, Chile

Department/Unit: *Department of Mental Health*

Country/Location: Chile

Submission

- El Action Plan presentado es un avance y una herramienta orientadora útil para el desarrollo de estrategias y planes de acción a nivel nacional y regional. A continuación, algunos comentarios:
- En el capítulo “PROPOSED OPERATIONAL OBJECTIVES FOR THE ACTION PLAN, GUIDING PRINCIPLES AND KEY AREAS FOR GLOBAL ACTION”, la relación entre objetivos, componentes, principios y áreas de acción de la Global Strategy y el Action Plan, resulta confusa. Lo mismo, con ciertos conceptos usados, como “guiding principles” vs “operational principles”, “target areas” vs “key areas”, “action plan” vs “global action”. Se sugiere, para el cuerpo del documento incluir son los contenidos que corresponden al Action Plan, trasladando a un Anexo la relación con objetivos, principios y áreas de la Global Strategy.
- Las áreas 3 “PARTNERSHIP, DIALOGUE AND COORDINATION” y 6 “RESOURCE MOBILIZATION”, resultan muy desafiantes. En estos casos, los targets y acciones planteadas representan propósitos más que metas, acciones o productos concretos, a diferencia de lo que ocurre en las otras áreas. Esto dificulta su uso como orientación específica para los desarrollos nacionales y también dificultará el monitoreo del cumplimiento del plan. Se sugiere revisar.
- En relación al área 1 “IMPLEMENTATION OF HIGH-IMPACT STRATEGIES AND INTERVENTIONS”, SAFER es una herramienta muy útil y organizadora para estas líneas. Resultaría también útil contar con estándares de desarrollo mínimo a nivel nacional/regional, aún cuando se entiende que las realidades son muy diversas: ¿Cuáles son las acciones mínimas que debieran emprender los países a 2025/2030, para reducir el consumo de alcohol?
- En relación al área 2 “ADVOCACY, AWARENESS AND COMMITMENT”, se señala como meta el desarrollo de políticas nacionales, pero no de planes de acción nacionales. Las políticas pueden no definir metas, responsables o tiempos, y muchas veces no constituyen herramientas concretas de compromiso. Las encuestas OMS usualmente indagan también sobre el desarrollo de planes. Se sugiere incorporar como metas el desarrollo de planes nacionales, así como también como acción específica y clara, dentro de los desarrollos esperables en estados miembros. También se sugiere incorporar explícitamente la necesidad y compromiso de incluir objetivos/metast relacionados con la reducción del consumo de alcohol (de riesgo) dentro de planes nacionales en temas relacionados con ENT, cáncer, obesidad, salud mental, etc., es decir, en áreas en las cuáles el vínculo con el consumo de alcohol es muy importante.
- En el área 3 “PARTNERSHIP, DIALOGUE AND COORDINATION”, se sugiere indicar de manera más clara que el diálogo relacionado con la contribución de la industria debe estar enmarcado en las políticas y planes nacionales para reducir el consumo de alcohol, así como en las intervenciones y estrategias de más alto impacto de acuerdo a la evidencia científica. Resulta un poco ambigua la manera en que está descrita esta área y podría dar lugar a la intromisión de la industria en la determinación de políticas sobre alcohol, con el conflicto de intereses que eso representa.

Ministry of Health, Welfare and Sport

Department/Unit: *Nutrition, Health Protection and Prevention*

Country/Location: Netherlands

URL: www.minvws.nl

Submission

please see the attached documents for our reaction

Attachment(s): 1

00095_07_nl-commentglobalstrategydec2020-11dec.pdf

Reaction regarding WHO consultation on the action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Commentary of the Netherlands

In the view of the Netherlands, the most important achievements of the WHO Global Strategy are:

- keeping alcohol on the political agenda;
- describing the harmful use of alcohol on the regional and global level in terms of morbidity and mortality;
- formulating evidence based measures to reduce the burden of disease of alcohol misuse, highlighting the most effective measures;
- and monitoring the implementation of these policy measures and their effects on global health indicators.

The goals of the current global strategy have only partly been achieved. The burden on public health caused by the harmful use of alcohol is still high and alarming: alcohol consumption remains one of the leading risk factors for health worldwide, causing 3 million people to die each year.

In our opinion, the priority in the near future should be to keep alcohol high on the global, regional and national political agendas, as a separate topic, not merely as part of the NCD's. It is evident that the harmful use of alcohol is not only visible in terms of NCD's, but also has significant impact on public health (traffic injuries, violence) and social problems (family problems, poverty, and absenteeism).

The Netherlands welcomes the WHO released Working document for development of an action plan to strengthen the implementation of the Global Strategy to reduce the harmful use of alcohol. With regard to the uneven and insufficient progress with the implementation of the Global Strategy, WHO has formulated six comprehensive domains of actions, number one being the implementation of high-impact strategies and interventions. There is more than enough scientific evidence on effective policy measures to reduce harmful alcohol use, but implementation of these measures remains the main challenge. The action plan well describes the targets and proposed actions for member states, the WHO secretariat and international partners and non-state actors.

We expect that these specifications, as well as the proposed detailed timelines, will contribute to speed up implementation of the actions needed. We would however like to stress the need of frequently monitoring the progress in actions on all levels, and would welcome a mid-term overall evaluation of the action plan.

The document needs in our view some elaboration on the role of economic operators in the overall ambition to reduce harmful alcohol use. The document is a bit ambiguous in this respect. It would be helpful to have more guidance of the WHO Secretariat on where economic operators may contribute to the general or more specific objectives of the action plan.

It is stated in the current action plan 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". Given the experiences with existing regulatory frameworks as a tool for supporting or modelling and implementing national policies we would welcome a study into the feasibility of international mechanisms for alcohol control. Such a study could be carried out by the Secretariat in collaboration with independent experts.

The Netherlands would like to express our appreciation of the work of the WHO Secretariat in preparing this important Global Strategy and action plans to reduce the harmful use of alcohol and its contribution to improve public health.

Ministry of Social Affairs and Health, Finland

Department/Unit: *Department for Safety, Security and Health*

Country/Location: Finland

Submission

1. The starting point of developing an action plan in order to better implement The Global Strategy is appropriate. At the moment there is no need to negotiate a novel Global Strategy, even though there are additional needs for international high level talks.

The working document addresses generally the most important of them: There is no legally binding regulatory instrument, which would for example protect member states' public health policies from the interference of international trade agreements and commercial interests.

2. The working document outlines rigorously the basis of the international alcohol policy and summarizes also the new developments concerning the opportunities and threats around the issue. As such it is a helpful document for everyone working in order to reduce alcohol related harm.

3. From the facts in the document one of the main questions arise: How is it possible that a global health problem responsible for this amount of mortality, morbidity, crime, family disruption and harm to children remains relatively "untouched" by political will, media interests and public calls for more effective counter measures?

There are several global, national and individual answers and they are not simple.

4. From the economical point of view it is important to notice that we are dealing with a market failure. There is a strong need correct this defect with public policy.

In all countries, the production and sale of alcoholic beverages generates profits for farmers, manufacturers, advertisers and investors. Alcohol provides employment for people in bars and restaurants and generates tax revenues for the government.

However, the benefits connected with the production, sale and use of this commodity come at an enormous cost to individuals and society. There are also externalities involved: the costs of selling or using alcohol spill over onto other parties. The generator of the externality does not have to pay for harming others and exercises too little self-restraint: In economic terms we say that "the market fails".

Public policies can correct this failing, but benefits and costs are very hard to estimate and compare with each other, there are cultural traditions which are hard to break and there are also different lob-bying groups that will and can affect the politicians. It is quite clear, that any kind of regulation that interferes with economic activities will also have opponents. So it is quite natural that different nations impose different restrictions or taxation for the market of this harmful commodity.

One of the main problems here involves the economic integration of Europe as well as the Agreements made within The World Trade Organisation. It seems that the main idea behind these systems is based on the fact that economic growth normally creates welfare. However from the evidence base also in the working document it is questionable, if more welfare may be created through more alcohol trade and consumption. Too little attention is given to the issue, if the marginal social utility of alcohol trade

actually is negative. That is: If the social cost of extra unit of alcohol consumption really exceeds all benefits, there should indeed be a clearer focus on both public health and also other policy areas.

From this it is also clear that all influence of the commercial trade interests must be disqualified in the developing and forming the Action Plan.

5. The working document addresses the need for multisectoral coordination and cooperation. This is a vital issue as there are many aspects that need to be united:

Alcohol policies are seen primarily as part of the general health and welfare policies. This is right, but also other policies must be involved. The concept of “Health in all policies” is a generic term comprising all concepts and activities that aim at integrating health in other policies. We should be able to highlight the need for “Reducing alcohol harms in all policies”.

One important note:

The working document refers to links with f.ex. Mental health action plan and the Global plan on action to address interpersonal violence. Probably all member states have similar specific strategies, action plans and programmes which have a connection with alcohol use and harms. Even though alcohol use may be the biggest contributory or background factor behind the need for these special plans, the possibilities of effective alcohol policy are seldom addressed properly. Instead specific strategies, plans and programmes usually focus on a number of all other general and specific (and often expensive) measures, probably considering that alcohol policy should be left alone or taken care only by alcohol policy makers.

In addition to the need to engage other policy areas in international cooperation and national governments (taxation, employment policy, trade agreements), there are several unused opportunities to engage different specific health policy sectors as well.

6. The Executive board also addressed the important issue of cross border alcohol marketing, advertising and promotional activities.

In this respect social media has become a new venue for promotion, and alcohol is no exception.

Social media advertising monetizes and uses consumers’ private networks. In it’s gravest form consumers are expected to share alcohol advertisements between themselves - from a friend to a friend. This is something that should be prevented:

For the first, social media marketing is always basically social or peer-to-peer and research shows that this is precisely the type of marketing that evoke high emotional arousal among young people. Children get more involved in marketing, when it’s “social”.

For the second, although social networks such as Facebook claim they are able to control user’s ages, this is not true. No-one can control age verification if the marketing is based on peer-to-peer relationships.

The problem of uncontrolled social and digital alcohol marketing is growing. One country alone is not able to solve problems in the digital world, but several countries may start trying to address these issues

in different ways. With the help and the support of the Action Plan, some countries would possibly start regulating also new forms of social and digital alcohol marketing. This would create pressure to make also international decisions.

In the end we need a global solution - f.ex. a WHO agreement on alcohol marketing.

Attachment(s): 0

Movendi International

Country/Location: Sweden

URL: <https://movendi.ngo>

Submission

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

Our submission is divided into three parts:

1. General feedback about what we support and what we want to improve
2. Specific comments on what we disagree with.
3. Detailed proposals for the elements and structure of the action plan.

We also include an Annex.

Summary of action points and recommendations

In addition to the actionable suggestions underlined in the text above, we also summarize here suggestions, proposals, recommendations and concerns we hope will be reflected in the action plan.

1. Ensure bold targets and ambition

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.

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. There are 7 opportunities listed in total. We propose the addition of five more opportunities, and we suggest the removal of 3 challenges. In general, we recommend that the analysis of the challenges and opportunities better reflects in other parts of the action plan all key lessons learned in the last ten years.

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

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.

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.
4. Ensure greater focus on the SAFER strategies.

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.

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.

We recommend annual WHO publications about alcohol harm and/ or policy development issues – as done in tobacco control, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We call for more frequent reporting 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.

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

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.

Attachment(s): 1

00508_28_movendi-submission-who-consultation-working-document-who-gas-action-plan-2020-final.pdf

Our submission – three parts

Movendi International is the largest independent global social movement for development through alcohol prevention. We unite, strengthen, and empower civil society to tackle alcohol as a serious obstacle to development on personal, community, societal, and global level. We are 135 member organizations from 54 countries and in 2019 together we reached more than 90,000,000 people. We stand for the most comprehensive response to alcohol harm, working with prevention and treatment and rehabilitation, as well as with advocacy, awareness raising campaigns and to expose and counter the unethical business practices of the alcohol industry.

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

Our submission is divided into three parts:

1. General feedback about what we support and what we want to improve
2. Specific comments on what we disagree with.
3. Detailed proposals for the elements and structure of the action plan.

General Feedback on the working document

In general, we welcome and support large parts of the working document as elements of the future action plan. In fact, it is our conviction that the working document contains the elements necessary to draft an action plan that can deliver on what Member States called for: making alcohol harm a public health priority and accelerating action on alcohol policy development and implementation. Some elements can be improved, some elements are missing, and some elements should be reworked, and some should be removed. Our submission will detail what that means and how this can be done concretely.

We make our proposals after detailed analysis of the working document, the WHO GAS itself, other WHO action plans and based on our own report about the last decade of WHO GAS implementation.

Setting the scene – what we support

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 is a good example of a missed opportunity to adequately address alcohol in all aspects of the harm it causes when the GPW13 was initially drafted and adopted; and 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.

We also welcome and support the strengthening of WHO's mandate for leadership and action in making alcohol harm a public health priority and accelerating action on alcohol policy development – as called for by Member States.

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 and the need for policy coherence,
- 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.

Setting the scene – what we want to improve

While we welcome and support the global action area targets and the indicators listed in Annex I, we miss one or two overarching target that underpin 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.”

1. We propose a bold and ambitious overall target of a 30% reduction of per capita alcohol consumption until 2030.
2. 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.

The setting the scene section can be further 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 global alcohol action plan immediately within wider efforts to achieve universal health coverage and to reach the SDGs.

WHO mandate – what we support

The action plan has the purpose to improve implementation of the WHO GAS. We therefore welcome that the introduction of the working document emphasizes the strong mandate that WHO has received with the adoption of the WHO GAS in 2010 to support action on alcohol harm on national, regional and global levels.

This is important because it should inform WHO's resource allocation and engagement with Member States with regard to alcohol harm and it highlights that Member States are looking to WHO leadership, normative guidance and technical support – something that is crucial to facilitate adequate responses to the alcohol burden across regions and in countries.

Growing member state commitment to tackle alcohol harm – what we support

Since 2010, member states have acted both at the UN and the World Health Assembly to strengthen their commitment through further landmark decisions to advance health and development through alcohol prevention and control.

We support that this is outlined in the setting the scene section. This matters because it shows that a) the evidence-base for alcohol policy-making has grown in the last decade, b) the global consensus has strengthened around the need for alcohol policy development; and c) the mandate of WHO in particular and the UN system in general has further been solidified over the last ten years of WHO GAS implementation.

The launch of the SAFER initiative at the high-level side event during the 2018 UN General Assembly is a landmark achievement that in itself illustrates the three points above.

Since the launch of the SAFER initiative country-demand for alcohol policy development and implementation has risen, showing the interest in and need for a technical blueprint and a partnership initiative for alcohol policymaking among countries around the world.

Taking stock of WHO GAS implementation – what we support

We largely 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. Please see below for detailed proposals.

We support the emphasis that in the last decade “no tangible progress was made in reducing total global alcohol consumption per capita”. This is a concern that many Member States gave voice to during the deliberations on alcohol harm as public health priority at the WHO governing body meetings on global and regional levels in recent years.

We note that the WHO European Region is on track to reach the target of a 10% per capita alcohol use reduction; this is good news for the heaviest alcohol consuming region in the world. Nevertheless, this fact should not obscure that large parts of the region have not done well in developing evidence-based responses to their respective alcohol burden and that the region overall benefits from significant reductions in alcohol use and harm in a few countries, such as Russia, other CIS countries, Lithuania and Estonia, as well as from young people in Western and Northern European countries staying alcohol-free longer and reducing their alcohol intake. This shows that there are

trends that support alcohol policy development and that when countries act to address their respective alcohol burden, significant improvements can be achieved. It also shows that the 10% per capita alcohol use reduction target applied on regional level does not provide the most accurate perspective to assess if more people actually are protected from alcohol harm.

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 behavior is a guiding principle of the WHO GAS and is part of the Human Right to health and the child rights provisions.

- Already in the section on setting the scene, this dimension should be expanded because of its significance for health and development in low- and middle-income countries worldwide. See below.

We also welcome and support the fact that alcohol's disproportionate burden on youth is included in the analysis. This is a major element of alcohol's health and development burden and should be further expanded because it provides for a clear and urgent case to accelerate action on alcohol and illustrates the large gains that can be achieved through alcohol prevention and control for population health, economic productivity and sustainable development.

Representing the largest global social movement for alcohol prevention and control, we are deeply concerned by the fact that "the implementation of the Global Strategy has not resulted in considerable reductions in alcohol-related morbidity and mortality and the ensuing social consequences." Reducing morbidity and mortality is the key goal of the WHO GAS. It has clearly fallen short of this ambition. We believe it is important to include a substantive analysis of this dimension in taking stock of WHO GAS implementation and make concrete proposals below.

Taking stock of WHO GAS implementation – what we want to improve

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 everywhere. Only 14% of reporting countries indicated high treatment coverage, i.e., treatment coverage of more than 40%. But 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.
- For the SAFER strategies there should be minimum quality standards developed, such as adjusting alcohol taxes to inflation, to establish global quality norms for alcohol policy development.

It is diplomatic but 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 from pressures to start consuming alcohol and supporting them in their “non-consuming” behavior is a guiding principle of the WHO GAS, but the fact that alcohol has become more available, comparatively more affordable and that marketing is reaching ever further into people lives shows that action has been inadequate to actually protect and support children, youth and adults who do not consume alcohol. The alcohol industry has completely failed.

- Attention to this dimension of alcohol prevention and control should be elevated because of its well-documented public health and sustainable development implications.

WHO GAS implementation challenges – what we support

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.

- ~~1. Complexity of the problem~~
- ~~2. Differences in cultural norms, contexts~~
- ~~3. Intersectoral nature of cost-effective solutions~~
4. Lack of political will and leadership at highest levels
5. Influence of Big Alcohol: interference and market power
6. Policy incoherence
7. Alcohol norm and cognitive dissonance
8. Lack of recognition of harm
9. Absence of legally binding instrument
10. Capacity to deal with informal alcohol
11. Alcohol marketing, including digital, satellite and CSR
12. Online retail and on-demand delivery challenging ability of governments to control alcohol availability
13. Scarce technical capacity
14. Scarce funding, human resources
15. Insufficient monitoring and surveillance systems

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.

But we disagree that the first three items should be framed as challenges to implementation of the WHO GAS in general and the alcohol policy best buy solutions in particular and will elaborate on that below.

WHO GAS implementation challenges – what we want to improve

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 followed by the others.

The discussion about the need for a global binding instrument for alcohol is at least as old as the discussion about the WHO GAS. But alcohol remains the only psychoactive substance that is not under any binding international control regime, despite the massive global alcohol burden. That is a significant reason why protections against alcohol industry interference are missing and why the alcohol industry continues to pose the biggest challenge to successful, evidence-based 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. Movendi International is tracking and exposing these actions on daily and weekly basis. The alcohol industry also leverages 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 the lack of political leadership and in turn policy coherence. A vicious cycle. When there is leadership, usually countries are capable of prioritizing the human right to health – as recent good examples from Scotland, Ireland, Russia, Lithuania, Estonia, Vietnam, etc. are showing; 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.

WHO GAS implementation challenges – what we disagree with

- 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. This is not to say that it is easy to advance alcohol prevention and control or that alcohol harm would not be pervasive, affecting multiple areas of society and sectors of policymaking. This is to underline that the magnitude and pervasiveness of alcohol harm is not a challenge but a reason for urgent and comprehensive action – and that solutions are available to move forward swiftly.

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 rates 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. On analysis, the alcohol norm, alcohol myths, alcohol industry interference, and alcohol marketing practices are actually rather similar and travel across cultures and countries – because of corporate drivers. People in Sri Lanka and Thailand know about Oktoberfest, as people in Africa are being taught that alcohol use is associated with wealth and status; women across the world, no matter whether they are in India or the United States, in Germany or in South Africa, are being conditioned to think that alcohol use is empowering, and a coping tool for daily stress. 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.

- Therefore, we urge for the removal of this point from the list of challenges, or a much more nuanced and evidence-based exploration, which likely does not fit into the context of the action plan.

Thirdly, having advanced the concept of “Alcohol in All Policies” in the last decade, we understand that intersectoral approaches to societal problems, such as alcohol harm, are not easy: they require institutional mechanisms, collective learning, joint efforts and interest as well as commitment of individuals to change “the old” way of solving problems; but we disagree 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 and outweigh the costs and challenges.

- Therefore, we recommend that the focus be placed on the opportunity, not the difficulty – also to underpin the inclusion of “multisectoral action” as operating principle in the action plan.

WHO GAS implementation opportunities – what we support

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.

WHO GAS implementation opportunities – what we want to improve

In our work to partner with decision-makers and support civil society for developing evidence-based alcohol policy solutions, 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. Locating alcohol harm within a Human Rights and Child Rights, possibly also Women's Rights, context is a significant opportunity for the period until 2030.
 - WHO and sister UN agencies should develop normative guidance and produce global public goods on these topics in the near future – as part of the SAFER initiative, for example.
- 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 for generating momentum for alcohol policy making as catalyst for development.
- A fifth opportunity is the technical report WHO was tasked to develop by Member States 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.

Scope of the action plan – what we support

The first two sentences in this section probably belong more into the analysis of the challenges. But we welcome and support the scope of the action plan to comprise concrete action and significant improvements to the global governance and infrastructure 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 32 actions suggested for Member States and the 39 actions proposed for 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 – and we make proposals to that effect below. But we support the ambition, quantity and quality of the actions outlined because it signifies that its Member States' obligation to ensure their citizens are protected from alcohol harm through cost-effective, scientifically proven and WHO-recommended alcohol policy solutions. And the ambition, quantity and quality of the proposed actions 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, to support Member States, to develop normative guidance, to improve and sustain effective global infrastructure and to coordinate other UN programs and agencies on national and global level in support of Member States.

- These considerations should feature more strongly in the action plan.

In this context, we must also emphasize 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. The “NSA” concept is not helpful in the context of the WHO GAS implementation because of the fundamental conflict of interest on part of the alcohol industry. This is alluded to in the section on challenges. For a coherent and meaningful action plan the challenges identified should be reflected in the framework for action (see below).

- 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 – as the working document should clearly discuss (see above). Therefore, we make concrete suggestions for how the role of different stakeholders can be better reflected in the action plan.

Finally, we welcome and support the inclusion of the potential of alcohol policy to contribute significantly to achieving the triple billion target of WHO's GPW13 in the scope of the action plan. This paragraph is a welcome improvement of the analysis of alcohol's cross-cutting harm in other health areas than NCDs (and of course going far beyond health harm, as the working document outlines) and of alcohol policy's potential to help achieve objectives under all three goals of the triple billion ambition.

Scope of the action plan – what we want to improve

We propose that the first two sentences in this section (page 6) be moved to a more suitable section – such as the analysis of the challenges.

In general, we propose that the scope of the action plan is reflected by the following elements:

1. Vision and bold targets,
2. Partnership for action,
3. Framework for action, including the operational objectives and the priority areas for global action,
4. Implementation with the operational principles,
5. Infrastructure, and
6. Monitoring and evaluation.

These key elements better reflect the scope and ambition of the action plan.

From our perspective, it is crucial that along with the implementation dimension also the infrastructure dimension of the new action plan is being improved and strengthened. We have made proposals to that effect in previous consultation submissions and will bring back the most meaningful elements below.

Goal of the action plan – what we support

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.

Below, we will add additional sub-goals to underpin the overall direction and lend more depth to the goal of the action plan.

We also 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” not under the “goal of the action plan”. We make a proposal to this end, below.

But we are convinced that the issues are highly relevant. Especially coherent action across the Secretariat with regard to alcohol harm is crucial and needs to be improved. The fact that some WHO regions have fallen short of even addressing, let alone

responding adequately to the magnitude of alcohol harm in their respective countries underlines the urgent need for more and better coordination, global guidance and best practice exchanges.

Goal of the action plan – what we want to improve

As we've indicated above, this paragraph might serve its purpose better under the headline "implementation" not under the "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.

In terms of implementation, the focus of a section could be on global and national implementation of a "systems-based" approach to alcohol policy and what its requirements are, such as

- for WHO and each country to identify a strategic combination of responses for implementation over the short term (2–3 years), medium term (3–6 years), and longer-term (7–10 years).
- it should emphasize the need for institutional context and feasibility analysis, the development of investment cases and the collaboration with civil society.

Whole-of-government and multisectoral partnerships, as well meaningful community engagement, will be needed to achieve a coordinated, whole-of-system response which can deliver multiple benefits for health, the society, the economy and overall sustainable development. For more details, see below.

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.

In general, we recommend consistent language, stringent framing of key issues and clear wording of key concepts.

Proposed operational objectives – what we support

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 the action plan to better reflect the analysis of lessons learned in the operational objectives. To that end, we make proposals below.

- 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.

Proposed operational 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 – what we support and want to improve

We welcome and support the operational principles. We believe they add value in support of the overarching guiding principles of the WHO GAS.

As we have identified in our 2019 consultation contribution, WHO has lacked action to operationalize the WHO GAS guiding principles. More can and should be done to leverage the principles and we believe the set of operational objectives will facilitate more deliberate action in this regard.

In our view, the set of operational principles is not yet complete, and the entire section should be expanded with more explanations and substance.

Proposed operational principles – what we want to improve

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 policymakers, people, families, and communities (in a slight adjustment to the principle already on the list, last bullet point).

Proposed key areas for global action – what we support and what we want to improve

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. Below we will detail what that means and how this can be done concretely.

- 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.

In general, we do not think that there is an added value in itself to reduce the number of actions but as analysis shows that some might be repetitive, we make a proposal for more streamlined actions (see Annex).

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” section, as proposed below.

We ask for the action plan to illustrate that the operational objectives have a clear bearing on the global actions for WHO and Member States.

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.

As we have advocated for in previous consultation submissions, 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.

Proposed key areas for global action – what we disagree with

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.

The question is: after ten years of WHO GAS implementation, has the alcohol industry demonstrated that their actions contribute to protecting people, communities and societies from the harm their products and practices cause?

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.

Summary of action points and recommendations

In addition to the actionable suggestions underlined in the text above, we also summarize here suggestions, proposals, recommendations and concerns we hope will be reflected in the action plan.

1. Ensure bold targets and ambition

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.

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. There are 7 opportunities listed in total. We propose the addition of five more opportunities, and we suggest the removal of 3 challenges. In general, we recommend that the analysis of the challenges and opportunities better reflects in other parts of the action plan all key lessons learned in the last ten years.

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

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.

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.

4. Ensure greater focus on the SAFER strategies.

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.

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.

We recommend annual WHO publications about alcohol harm and/ or policy development issues – as done in tobacco control, where annual reports with different topics are produced to generate momentum for policy discussions and action.

We call for more frequent reporting 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.

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

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.

ANNEX

Why we make a suggestion for elements and structure of the action plan that are not in the working document

We make the suggestion for better structuring the elements of the action plan in order to improve the logic of the document, to ensure focus on implementation and the facilitation of concrete action, to illustrate currently missing elements that provide more depth and direction for global action, and to help better contextualizing our suggestions above.

Suggestion for elements of the action plan

We have studied other, similar global action plans developed by WHO and adopted by the World Health Assembly in recent years to analyze which elements are useful in the global action plan to improve WHO GAS implementation. The WHO Mental Health Action Plan 2013-2020, the Global Strategy for Women's Children's and Adolescent's Health 2016-2030, the WHO global health sector strategies on STIs and HIV as well as the WHO Global Action Plan for Physical Activity 2018-2030 were all useful and instructive. Learning from their examples, and from analysis of civil society partners working more closely in those other public health areas, we suggested that the action plan on alcohol consists of the following elements:

1. Vision and bold targets
 - To achieve a 30% reduction of per capita alcohol consumption until 2030.
 - To maintain the global percentage of past-year alcohol abstainers among the global adult population at 2016 levels.
2. Guiding principles

The action plan is informed by the following guiding principles that should underpin implementation of actions at every level as Member States, partners and WHO work towards achieving the shared vision of a world free from preventable alcohol harm.

The following principles should guide implementation – in addition to those included in the working document (avoiding overlaps and repetition):

- Prevention first,
- Proportional universality,
- Policy coherence,
- Alcohol in all policies – mainstreaming approach,
- Whole-of-government approach,
- Engagement and empowerment of policymakers, people, families, and communities (in a slight adjustment to the principle already on the list, last bullet point).

3. 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.

- This section should include the set of global actions for civil society.

Given that the agenda of the action plan is beyond the scope of any single agency, implementation demands partnership. By working together to achieve the vision of the action plan and improve health for all and promote the SDGs, partners can also accelerate progress to achieve their own respective goals.

Member States

ministries of health, transport,
education, sports, youth, urban planning, environment, tourism, finance, and labor

Development agencies

international financial institutions such as the World Bank, regional development banks, subregional intergovernmental organizations and development aid agencies

Intergovernmental organizations

UN agencies, UN Interagency Taskforce on NCDs (UNIATF) and others

International organizations

global health initiatives and agencies

Nongovernmental organizations
civil society, community-based organizations, human rights-based organizations, faith-based organizations

Professional associations
in medical and allied health areas, such as sports medicine, physical therapy, general practice, nursing, exercise and sports science, physical activity and public health and other relevant disciplines, including transport, sport, and education

Philanthropic foundations
that are committed to promoting global health and achievement of the SDGs

Academic and research institutions
across multiple disciplines including implementation science and the network of WHO collaborating centers

Media
journalists and media outlets, including both traditional and new media

City leaders and local government
mayors, governors and local officials

Community
representatives of faith-based, social and cultural groups

WHO
at all levels, headquarters, regional and country offices

3. Framework for action

Effective national action to reverse current trends in alcohol consumption and harms requires a “systems-based” approach with a strategic combination of “upstream” policy actions aimed at improving the social, cultural, political, economic and environmental factors that determine alcohol harm.

Six Priority areas for global action and eight operational objectives provide a universally applicable framework for the ambitious set of multidimensional policy actions, each

identified as an important and effective component of a population-based response to preventing and reducing alcohol harm in order to achieve health and development for all. In combination, they capture the whole-of-system approach required to create a society that intrinsically values and prioritizes policy investments in alcohol prevention and control as catalyst for sustainable development.

This global action plan sets out 8 operational objectives achievable through a set of policy actions that are universally applicable to all countries, recognizing that each country is at a different starting point in their efforts to prevent and reduce alcohol harms and to promote development through alcohol prevention and control.

- Operational objectives: 8
- Priority areas for global action: 6
- Global action: WHO
- National action: Member states

3. Implementation

National implementation of the alcohol policy best buys, and the SAFER solutions requires a “systems-based” approach.

That means that each country needs to identify a strategic combination of policy responses for implementation over the short term (2–3 years), medium term (3–6 years), and longer-term (7–12 years). Policy actions should be selected according to country context and tailored to meet the needs of the country’s population.

Prioritization and feasibility will vary according to context; therefore, it is recommended that each country assess their own current situation to identify existing policy which can be strengthened, as well as policy opportunities and gaps.

Cross-government and multisectoral partnerships, as well meaningful community engagement, will be needed to achieve a coordinated, whole-of-system response which can deliver multiple benefits for health, the environment and the economy.

Implementation of this action plan should be guided by the guiding principles.

Given that the policy agenda is beyond the scope of any single agency, implementation will require effective partnerships. All stakeholders can and should

contribute to the implementation of this global action plan at the national level, individually and in partnership in seven key areas:

- Leadership
- Policy and governance
- Coordination
- Resource mobilization

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".

- Community engagement
- Promotion and advocacy
- Evidence-based practice

4. Infrastructure and governance

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:

12. 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.
13. 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.
14. There is no Global Fund for Alcohol Prevention – like there is for HIV/ AIDS, TB and Malaria.
15. There is no global initiative to advance alcohol taxation (or alcohol marketing) – like there is for tobacco taxation.
16. There is no Interagency Coordination Group on alcohol harm – like there is for antimicrobial resistance (AMR).
17. There is no One Health Global Leaders Group on Alcohol Harm – like it was recently launched for AMR.
18. 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.
19. 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.
20. 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.
21. 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.
22. 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:

4. 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,

5. 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
6. 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”.

5. Monitoring and evaluation, review and reporting

To ensure accelerated action on the public health priority that is alcohol, effective monitoring and evaluation should be complemented with regular and compelling review and reporting.

Monitoring progress towards the 2030 global targets will be essential and should be done according the SDGs 3.5.1 and 3.5.2.

Population coverage of the alcohol policy best buys is another important aspect for regular monitoring and evaluation, as well as review and reporting to the WHO governing bodies for international dialogue.

Monitoring framework and indicators

All countries are encouraged to strengthen reporting of disaggregated data to reflect the dual priorities of this action plan: to decrease overall level of alcohol harm; and to reduce within-country disparities and levels of the alcohol burden in the least most affected populations, as identified by each country.

Reporting on global progress

A new global monitoring framework will support countries and monitor progress on policy implementation.

Progress reports on implementation and impact will be presented to the World Health Assembly in 2024, 2026, 2028 and 2030.

Movendi International Member organization, Population Health
Research Center Mongolia

Department/Unit: *Administrative*

Country/Location: Mongolia

URL: none

Submission

We made our input and comment for the document.

Attachment(s): 1

00433_68_movendi-members-who-workingdoc-consultation.pdf



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

Population Health Research Center Mongolia team is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

Our mission is to create healthy community through research evidence and supportive legal system in the field of alcohol, tobacco and drug issues in Mongolia.

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.
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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.
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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.

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Movendi Slovakia

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Submission

Content of the submission overview

A. 7 Points for Action Plan Improvement

1. Ensure bold targets and ambition

- 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.

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.

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

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

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. Streamline the global actions by avoiding repetition, reducing overlap and adding prioritization;

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.

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

4. Ensure 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.

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.

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.

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.

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.

B. Additional point to be added to the action plan

1. Suggestion for elements of the action plan

We would like to suggest the following set of elements of the action plan:

- Vision and bold targets
- Partnership for action
- Framework for action

C. Point of criticism and request for significant change

1. Role of the alcohol industry, conflict of interest

We 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 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

00497_21_movendi-slovakia-who-workingdoc-consultation.pdf

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

Movendi SK is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

Movendi SK is a Civil Society Organization promoting health and healthy lifestyle in Slovakia focused especially on preventing harm caused by alcohol.

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”.

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‘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.

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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.

Nada India Foundation

Country/Location: India

URL: <https://www.nadaindia.info/>

Submission

Nada India 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*.

Nada India advocates for balanced and healthy public policies to prevent, control non- communicable diseases and promotes child friendly, gender sensitive and alcohol/drug free healthy life style.

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

00459_86_nada-india-who-workingdoc-consultation-2.pdf

www.nadaindia.info

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

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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.

National Alliance for Action on Alcohol

Country/Location: Australia

URL: <http://actiononalcohol.org.au/>

Submission

In general, there is an opportunity to reference the integration of alcohol control with broader health and development agendas, including:

- An explicit reference to policy coherence between public health and other sectors/policies in relation to alcohol control.
- References to human rights – although this is listed in an ‘operational action-oriented principle’, there are no further references – this could be added to sections on consumer information (right to information and right to health) and the right to health is relevant to a number of other areas too, including high impact interventions, data, plans, and participation of civil society.
- Additional references to sustainable development, including explicit reference to SDG targets on NCDs and on road safety as well as on alcohol, and references in action areas 1 (high impact interventions) and 3 (partnership, dialogue and coordination)

Attachment(s): 1

00303_67_global-strategy-on-alcohol-harm-4-dec-2020-aust.pdf

Ms Jane Martin
Co-Chair, National Alliance for Action on Alcohol

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 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 and have the following comments and suggestions for your consideration.

The National Alliance for Action on Alcohol (NAAA) is a coalition of health and community organisations from across Australia which aims to reduce alcohol-fuelled harm. The NAAA was formed in 2009 and represents more than 20 organisations representing a diverse range of interests, including public health, Aboriginal and Torres Strait Islander health, child and adolescent health, family and community services, and people with lived experience of alcohol-fuelled harm.

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 the harmful use of alcohol and the ensuing social consequences.

In general, there is an opportunity to reference the integration of alcohol control with broader health and development agendas, including:

- An explicit reference to policy coherence between public health and other sectors/policies in relation to alcohol control.
- References to human rights – although this is listed in an ‘operational action-oriented principle’, there are no further references – this could be added to sections on consumer information (right to information and right to health) and the right to health is relevant to a number of other areas too, including high impact interventions, data, plans, and participation of civil society.
- Additional references to sustainable development, including explicit reference to SDG targets on NCDs and on road safety as well as on alcohol, and references in action areas 1 (high impact interventions) and 3 (partnership, dialogue and coordination)

The broad coalition of interests represented by the NAAA highlights widespread concern in Australia about alcohol-fuelled harm and recognises the importance of cross-sector community partnerships. The impacts of alcohol are far-reaching, and Australian governments urgently need to implement policy changes as part of a coordinated strategy to drive and sustain action on this pressing community issue.

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

In general, there could be more references to integration of alcohol control with broader health and development agendas, including:

- An explicit reference to policy coherence between public health and other sectors/policies in relation to alcohol control (maybe in action area 3)
- References to human rights – although this is listed in an ‘operational action-oriented principle’, there are no further references – this could be added to sections on consumer information (right to information and right to health) and the right to health is relevant to a number of other areas too, including high impact interventions, data, plans, and participation of civil society.
- Additional references to sustainable development, including explicit reference to SDG targets on NCDs and on road safety as well as on alcohol, and references in action areas 1 (high impact interventions) and 3 (partnership, dialogue and coordination)

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.

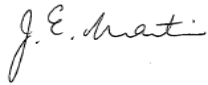
There are also areas where the Action Plan can be strengthened, including:

- 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.
 - High impact interventions (action area 1, action 3) – strengthen language from ‘are invited to contribute to the elimination of...’ to ‘should refrain from marketing and sales of alcoholic beverages to minors ... and take other actions to contribute to the elimination of such marketing practices’ (rather than
 - Dialogues with economic operators in action area 1, action 4 and action area 3, action 6 for Secretariat – needs to explicitly acknowledge that these dialogues should include adequate safeguards against conflict of interest in line with FENSA and SAFER.
 - capacity building (action area 4, action 3 for non-state actors) – we do not believe that industry should be invited to implement capacity-building activities.

- data collection (action area 5, action 6 for Secretariat and Action 3 for non-state actors) – this needs to acknowledge the need to ensure that industry-generated data is independently verifiable.
 - reducing alcohol harm (action area 6, action 3 for non-state actors) – this should be amended from ‘are invited to refrain’ from lobbying etc to ‘should refrain’.
- Having a greater focus on governance, resourcing, review and implementation.
 - There is only one indicator for implementation of all policies (target 1.1). There needs to be something that specifically monitors which of the measures have and have not been implemented to allow for accurate monitoring of progress, accountability, and effective targeting of assistance for implementation – the indicator should either be disaggregated into individual SAFER policies, or the indicator should also track number of policies for each country and refer to a more detailed monitoring framework elsewhere (e.g. under SAFER).
- 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 the opportunity to participate in this consultation and we hope our efforts contribute to a reduction in the harms caused by alcohol products.

Best wishes,



Jane Martin, Co-Chair

National Drug Research Institute

Country/Location: Australia

Submission

The National Drug Research Institute welcomes the opportunity to comment on the Global Strategy to Reduce the Harmful Use of Alcohol Working Document.

We commend the authors for the accessible and succinct summary of the key issues and harms, the burden felt across countries, civil society and individual communities. We note and support the clear message about the importance of strategies to prevent and manage alcohol related harm to ensure health and wellbeing, for global public health.

We note the following:

In the Working Document that has been circulated, we are particularly concerned that, after strong statements relating to concerns about “the influence of powerful commercial interests in policy-making and implementation ...”, it is suggested that the various alcohol industries are stakeholders in what is essentially a health issue – they are stakeholders who have a commercial interest at heart, not a health one. We are concerned at the apparent equivalence with civil society, U.N. organisations and affected individuals in our communities. The alcohol industries’ commercial conflict of interest, and indeed the Working Document itself, provides illustrations that argue against such a position. The alcohol industries’ interests should be considered elsewhere, not as a key focus of protecting our communities’ health and wellbeing.

- It is important to also identify other conflicts of interest. As noted in the document, there are diverse government departments interested in alcohol. These commercial interests (e.g. trade, tourism) often act in conflict with public health interests. Identifying these conflicts and outlining effective responses is critical.
- In relation to strategies, there is a substantial evidence base outlining the most cost-effective policies and strategies to prevent and reduce alcohol-related harms. These should be key to the strategy sections.
- The Guiding Principles should include reference to the right of people to be protected from the outcomes of other people’s drinking – this is referenced elsewhere but should be given prominence in the Guiding Principles.
- We note the comment that:

“Satellite and digital marketing present a growing challenge for the effective control of alcohol marketing and advertising. 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.”

We strongly support this recognition of the challenge of marketing and remote supply and believe this needs to be urgently examined, and their impact on risk and harms included in reporting.

- In the section on effective monitoring (pp18-19), we suggest emphasising:
 - o Currency of data;
 - o Data including the capacity to identify issues and needs of vulnerable populations, particularly as this is identified as a key issue; and,
 - o Data that can quickly identify changes in patterns of use and, where required, at local levels; sales or taxation data can achieve this objective, it is unlikely reliance on self-reporting can or will.

Attachment(s): 0

NCD Alliance

Country/Location: Switzerland

URL: <https://www.ncdalliance.org>

Submission

The NCD Alliance thanks the WHO for preparing the working document and offering the opportunity to contribute comments. NCDA commends the WHO secretariat for the working document advancing on the process to develop an action plan. We are pleased to see this progress in strengthening the governance framework for alcohol. Ultimately this action plan must help save and improve millions of lives currently harmed by alcohol, many of which are due to the toxic, psychoactive and carcinogenic characteristics of the substance contributing to noncommunicable diseases (NCDs) including of the neurological, cardiovascular and gastrointestinal systems, including at least 8 cancers. All harm caused by alcohol is entirely preventable, and yet alcohol continues to be a leading cause of premature mortality and morbidity in many countries of the world. We will not achieve progress necessary on NCDs and SDGs if we don't accelerate action assertively and rapidly.

Our submission attached includes constructive feedback and recommendations for the next phase of development of the action plan.

Attachment(s): 1

00522_34_ncd-alliance-submission-to-who-alcohol-ap-working-document-dec2020-final.pdf

**NCD Alliance Submission to WHO consultation on
Working Document to develop an action plan for strengthening implementation of the
WHO Global Strategy on the Harmful Use of Alcohol (GAS)**

December 2020

The NCD Alliance thanks the WHO for preparing the working document and offering the opportunity to contribute comments. NCD Alliance commends the WHO secretariat for the working document advancing on the process to develop an action plan. We are pleased to see this progress in strengthening the governance framework for alcohol. Ultimately this action plan must help save and improve millions of lives currently harmed by alcohol, many of which are due to the toxic, psychoactive and carcinogenic characteristics of the substance contributing to noncommunicable diseases (NCDs) including of the neurological, cardiovascular and gastrointestinal systems, including at least 8 cancers. All harm caused by alcohol is entirely preventable, and yet alcohol continues to be a leading cause of premature mortality and morbidity in many countries of the world. We will not achieve progress necessary on NCDs and SDGs if we don't accelerate action assertively and rapidly.

Within this response, the Global Alcohol Strategy is abbreviated to GAS

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:

Positives

We particularly commend the following points of the action plan as advances on the global alcohol strategy:

- **Clear language with a logical structure**, and introduces specific proposed actions for different stakeholders in pursuit of newly identified global targets for reducing alcohol harm.
- **Comprehensive background** outlining the rationale for the action plan, purpose, aim, and vision, barriers to progress and deficits of a global alcohol strategy which has not evolved to reflect more recent developments.
- The identification of **civil society** as important stakeholders in particular with regard to advocacy, monitoring and evaluation of GAS and implementation of the future action plan.
- Acknowledges the **need for greater political will**, leadership and resources to implement the GAS.
- Notes the **harmful impact of the alcohol industry** and other vested interests on implementation of the GAS.
- **Advances on the GAS with integration of recent developments** such as evidence based, cost effective 'Best Buys' and other recommended interventions for prevention and control of NCDs, including specific action area relating to the technical initiative SAFER.
- As civil society partners of the SAFER initiative, **we welcome SAFER's inclusion** as a key area for action, and the potential that this package provides for strengthening implementation, and monitoring and evaluation of implementation, of these alcohol related 'Best Buys' NCDs prevention if sufficiently resourced at all levels. While all

action areas of the GAS provide opportunities to save lives, it is through focussing on and unifying around these included in Global action plan on Prevention and Control of NCDs and its associated global monitoring framework for NCDs where we have the greatest potential for progress.

Based on the working document, NCD civil society feels the action plan will provide much needed impetus to civil society to call for governments to implement the global alcohol strategy including national alcohol policies.

Greatest barriers needing to be addressed by this action plan

Despite optimism about the working document, the NCD community retains considerable concerns that the working document currently falls short of informing an action plan which sufficiently address what it understands to be the most significant barriers to progress on alcohol harm reduction. Some of the main persistent barriers identified:

- **Lack of political leadership** and recognition of the social, health and economic costs of alcohol, and the risks of engagement with the alcohol industry - including producers, retailers and marketers.
- **Lack of resourcing** to build strong coalitions, political capital and resilience to challenges throughout introduction of legislation, and resourcing to support comprehensive implementation including enforcement and reporting. This includes a need for greater investment in alcohol harm prevention from funders, donors, domestic resource mobilisation (ie taxes on alcohol), and in kind contributions from those without alcohol interests.
- **Alcohol industry interference**, influence, lobbying and participation in the decision making processes.

One of the greatest concerns and barriers identified by NCD advocates pertains to the **disproportionate power and influence of the alcohol industry** delaying policy implementation, dividing with diluted strategies such as voluntary or self-regulation, deflecting with false claims, and denying and casting doubt on evidence.

Protection of the process to develop the action plan

The alcohol industry, like others whose products and practices contribute to harm, is represented by a very strong lobby, and has a fundamental conflict of interest much of the working document. It is envisaged that the industry will not only resist many aspects of this working document at both local (community and national) and global levels, but they will actively lobby against its adoption over the coming 18 months. It is critical that the action plan be robust, and that the processes around its development are protected from these conflicted interests. We urge Member States to put human rights at the centre of decision making for NCD prevention and control, and not allow the interests of the alcohol industry to negatively influence their input into this action plan as it develops at a potentially catastrophic cost to human health and lives. Should the industry dilute this action plan, and further stall progress in doing so, then we would urge accelerated advancement toward exploration of a binding international instrument which protects people and policy making from the interests and influences of health harming industries.

Recommendations and Reservations

There are several areas of the working document the NCD community has identified as opportunities for strengthening the action plan based on the working document, as outlined below.

SAFER – We welcome the integration of SAFER into the working document as a key and primary Action Area, however given SAFER encompasses the 5 main ‘Best Buys’ for alcohol we recommend that SAFER be referenced by name in the operational objectives (point 1).

Alcohol Industry / ‘economic operators’

One of the most concerning aspects of the working document is the **integration of ‘economic operators’ throughout** alongside and in equivalence to UN and other partners, and civil society. Given the significant role of so called ‘economic operators’ - itself a problematic reference - in alcohol harms and contributing to the 3 million deaths occurring every year, they should not have an integral role through the implementation of the action plan, and should instead have a separate paragraph speaking specifically to the actions that they must take to reduce their contribution to the problem.

The term ‘economic operators’ is counterproductive - a vague, yet positive and powerful reference to alcohol industry actors by emphasising their role in economies while downplaying their role in health and social harms, costs and externalities. The term should be updated to refer specifically to such ‘economic operators’ as the ‘alcohol industry’ with a broad definition including all those with economic interests including in the production, sale, and marketing of alcohol products.

Any actions ascribed to the alcohol industry should be **instructive, not advisory or inviting**. For example, they should have no role in activities such as capacity building; they should cease marketing in ways which expose or appeal to youth; they should cease lobbying against effective policy.

Conflict of Interest -

Clear **guidelines on managing conflict of interest and industry interference** should be developed as an appendix to this action plan for all stakeholders, including WHO, UN agencies, and Member States, and should also be applied to SAFER implementation. The **Framework for Engagement of Non State Actors (FENSA)** should be updated to better reflect the alcohol industry in relation to conflict of interest, and to improve implementation of FENSA.

We urge **WHO to cease dialogue with the alcohol industry**, however any interactions which do take place should be reflected in strategies for managing conflict of interest in development and implementation of the action plan should include transparent **publication of details of interactions between the WHO Secretariat staff** (national, regional and head quarter divisions) and alcohol industry, detailing participants, costs, topics discussed and actions. A publicly searchable transparency register could house such information, and Member States could replicate this model.

The **WHO Framework Convention on Tobacco Control** is also a strong reference point for acknowledging the role of an industry vested in toxic, carcinogenic products like alcohol. This would be particularly valuable to consider in the context of developing and providing clear guidance on **corporate social responsibility** initiatives and linked partnerships, where lines blur between the industry 'doing good and being seen to be doing good', and the often conflicting interests of these favouring the alcohol industry.

Resources - this action plan should set out that one of its **prime objectives is to better resource WHO to provide support to strengthen Member State capacity**, which in itself will require and should request greater resources to support the WHO secretariat's normative and technical role; Further strong implementation requires civil society to undertake supportive and strategic advocacy, monitoring and campaigning which also requires greater investment. Furthermore, Member States must invest more to reap returns of up to \$7 per \$1 invested in SAFER measures, and also to develop aligned national action plans, implementation and reporting mechanisms.

Tone and language - Frequent references to stakeholders, particularly the alcohol industry, being '**invited**' to take specific actions confers a passive and *invitational voice*, while Member States and WHO are *instructed*. Such is the degree of harm and lack of progress, the action plan should take a more specific instructional tone around actions, particularly where they regard the alcohol industry.

Use of alcohol - Further, regarding language, as any use of alcohol increases risk of multiple forms of cancer it is more accurate to refer to '**use of alcohol**' removing reference to '**harmful**' use of alcohol as technically all use of alcohol carries a degree of risk of harm. Thus, the outdated reference to 'harmful use of alcohol' from the global alcohol strategy should be updated given most recent evidence to 'use of alcohol'.

Structure and design - the working document is a well drafted entree to the action plan, and we appreciate that the action plan presented to EB and WHA for consideration will be in a similar text based form, however we would envisage and hope that the final action plan package be structured and designed in a more accessible way using visual cues and summary boxes, and breaking into sections, and potentially summarised with annexes. Actions may warrant being listed in order of priority and/or impact.

Reporting, monitoring and evaluation -

Monitoring, evaluation, reporting and review mechanisms should be clear and applied to each SMART action, to ensure progress can be assessed; and should show or no progress warrant revision of the strategy for implementation of the action plan, this can be thus done accordingly on areas requiring greatest attention and in a timely manner.

The **action plan requires much clearer timelines and reporting points** on implementation of the action plan, and we specifically recommend these reporting points on action plan progress should be **every 1-2 years** (not as currently vaguely referenced to as 'periodically'), **through the WHO Executive Board and World Health Assembly**. Reporting should include updates against the actions within the action plan, strength and enforcement of

implementation of each action and policy area as relevant, any challenges faced by Member States, and the nature and extent of collaboration between UN agencies.

Reporting points should provide recommendations for further strengthening of implementation of the action plan, and opportunities for strengthening and revision if necessary (particularly if alcohol use and harm is increasing rather than decreasing).

As an issue which is dominated by but goes beyond NCDs, it should be considered that **reporting on the action plan on implementation of GAS should have a separate item on the WHO WHA agenda under the Healthier Populations pillar.**

To further accelerate progress and ensure adequate impetus and monitoring of implementation of the action plan, Member States could request the establishment of an **Expert Committee on alcohol harm reduction** in 2022 alongside adoption of the action plan.

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** to ensure there is no further delay to proportionately addressing any persistent barriers to progress identified through the course of the action plan.

Should progress toward action plan targets be insufficient by 2-3 years before the sunset point for the action plan in 2030 (ie **2027/2028**), then Member States should request that the **WHO commences exploration of the possibly and feasibility of measures and instruments to close specific gaps to progress, along the lines of an internationally binding instrument**, and review the evidence to assess how an instrument could contribute to a reduction in alcohol harm and an increase in alcohol control. Legal measures have proved effective in managing other NCD risk factors, particularly another comparable carcinogen causing extensive social and health harms, such as tobacco.

While civil society (including NGOs and academia) are well placed to take an active role in **independently monitoring, documenting and reporting on industry activities and interference**, this is a significant undertaking and requires sufficient resourcing, collaboration and coordination with Member States and WHO. Thus these stakeholders should be cited as also having a role to play in industry monitoring as they do with the FCTC and UN agencies in supporting implementation of the International Code of Marketing Breastmilk Substitutes.

The **media** could also be included as stakeholders having a role in ensuring accurate reporting, monitoring industry actions, and not exacerbating harmful alcohol-culture.

Register of actions - SAFER could provide a framework for a **register of stakeholder actions in the context of contributing to (or regressing) alcohol policies**, in support of the action plan implementation and reporting; This register could be categorised by stakeholder group and receive both formal as well as shadow reports, and mechanisms for defining 'SAFER' rated stakeholders such as countries, cities, and organisations.

Other Stakeholders – youth and people most affected - The **objectives** could also include a reference to the involvement of **youth and people living with alcohol related conditions or affected by alcohol use** as important civil society stakeholders in design of measures and other decision making processes.

SDGs and triple wins: While the primary responsibility lies with WHO and Member States, there could be **greater reference and specificity to the role of alcohol as a barrier to progress across the SDGs**, and thus greater reference to the **other stakeholders, sectors and UN agencies**, with roles and potential action areas and indicators to support achievement of the action plan and SDGs. This would foster greater multisectoral engagement and collaboration, and policy coherence. This would also facilitate more integrated reporting on alcohol indicators contributing to SDG progress through established SDG reporting frameworks. Alcohol's role across the 2030 Agenda has been well documented by Movendi International.

Further consideration and **mapping of the roles of other stakeholders** (ie UN agencies) 'multiple wins' or 'co benefits' across development that greater alcohol policy action would warrant attention to support action plan co-ownership.

To further strengthen implementation of the action plan, several enablers could be considered, which would facilitate co-ownership, momentum and awareness of alcohol harms; an **annual global alcohol harm awareness day** should be introduced; The **WHO Forum on Alcohol, Drugs and Addictive Behaviour** should continue however greater time and attention should be dedicated to alcohol, and be complemented with dedicated **ministerial convenings** on alcohol harm and facilitation of exchange of best practice and strategies to overcome barriers in action plan implementation;

It would be important to undertake further **cost effectiveness analyses for SAFER** and other GAS alcohol control measures in light of increasing recognition of co-benefits across SDGs and considering all country income groups.

Greater reference to cross cutting opportunities for action would be strengthened by a broader and more integrated application of a **human rights approach**, and consideration of common policy action areas, for example marketing restrictions to protect children from harmful commodity marketing (ie through an optional protocol to the Convention on the Rights of the Child). Furthermore reference to the opportunity to improve not only health literacy but also **consumers' commercial literacy**, including that of children, to support their scrutinising of industry tactics to drive consumer behaviour.

Objectives could be updated to include reference to monitoring of the alcohol industry, as a major barrier to progress, including industry interference, activities and their response to the action plan.

Final

We strongly urge WHO to develop an action plan which is robust and resistant to the interests of the alcohol industry, and to resist efforts by the industry to dilute it.

We also urge Member States to put the health of communities first and prioritise their interests rather than those of the alcohol industry when responding to consultations, inputting into and finally endorsing the action plan.

If this action plan fails to deliver progress within 5 years - particularly due to alcohol industry actions - investigation of stronger, binding measures should be activated.

We stand ready to continue to support the development of a global action plan on the global alcohol strategy, and look forward to working together with and supporting WHO and Member States to achieve an action plan which truly minimises alcohol's devastating harms on communities.

About this submission

The NCD Alliance (NCDA) is a unique civil society network of 2,000 organisations in 170 countries, dedicated to improving NCD prevention and control worldwide. Our network includes NCDA members, 65 national and regional NCD alliances, scientific and professional associations, and academic and research institutions. Together with strategic partners, including WHO, the UN and governments, NCDA is transforming the global fight against NCDs.

This submission was prepared by NCD Alliance's global advocacy team also informed by members of the NCDA network, including but not limited to

- ACT Promoção da Saúde (ACT Health Promotion, Brazil)
- American Academy of Paediatrics
- Cameroon Civil Society NCD Alliance
- Coalición México SaludHable
- Healthy India Alliance
- Kreftforeningen (Norwegian Cancer Society)
- McCabe Centre for Law & Cancer, Australia
- Movendi International
- Vital Strategies
- World Cancer Research Fund International
- World Obesity Federation

It is important to note that the several NCDA members would have appreciated an opportunity to review and comment on the working document in other UN languages, including French and Spanish, and look forward to reviewing the draft action plan in these languages at the earliest opportunity. Civil society members also welcomed the extension of the consultation period during a very busy period.

Nederlandse Brouwers

Country/Location: Netherlands

URL: <https://www.nederlandsebrouwers.nl/>

Submission

See attachment.

Attachment(s): 1

00365_31_contribution-of-nederlandse-brouwers-to-the-who-consultation-on-the-working-document-global-alcohol-strategy.pdf



Contribution of Nederlandse Brouwers to the WHO Consultation on the Working document for development of an action plan to strengthen the implementation of the Global Alcohol Strategy

On Nederlandse Brouwers

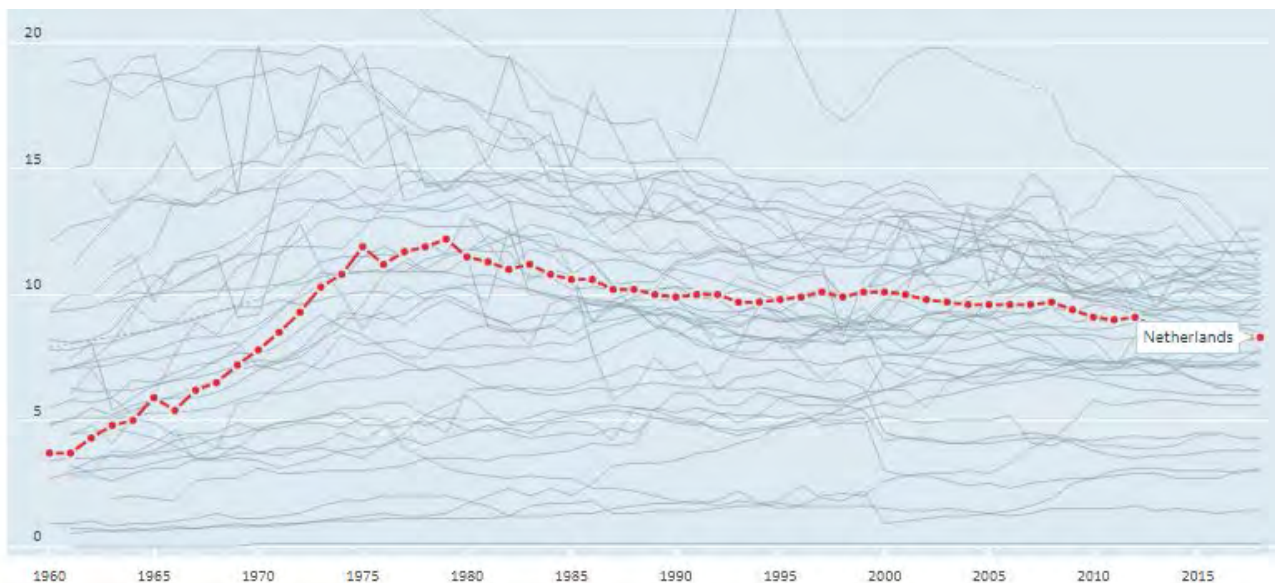
Nederlandse Brouwers is the association of Dutch beer breweries. One of the most important themes at the moment is responsible beer consumption. Not only for society, but also for the brewers. As brewers, we want to maintain the positive trend towards responsible alcohol consumption. To achieve this, Dutch breweries engage in several activities, like promoting non-**alcoholic beer, contributing to the national don't-drink-and-drive-campaign** and combatting alcohol abuse by students. Nederlandse Brouwers appreciates the opportunity to contribute to the consultation on the Working document for the Global Alcohol Strategy and would like to give the following information and recommendations.

1. Information on the trend of declining alcohol abuse in the Netherlands

Alcohol consumption continues to decline

Per capita consumption of alcohol has been in decline for a long period of time. The graph below shows the long term decline of consumption. In 1979 per capita consumption was 12,2 litres of pure alcohol per year. In 2018 it was 8,3 litres.

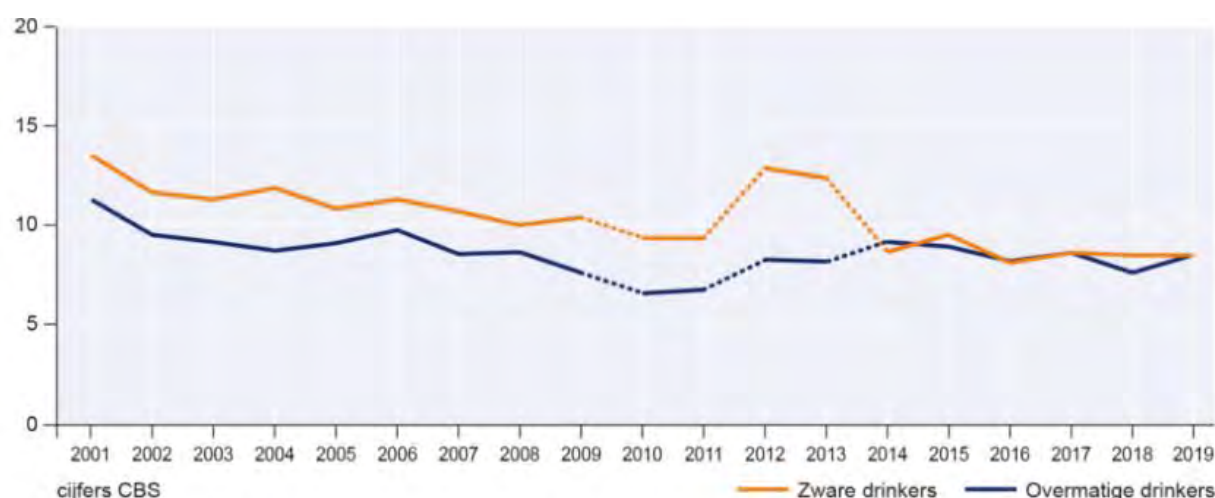
Graph 1: per capita alcohol consumption in the Netherlands



Source: [OECD](#)

More specifically, excessive and heavy episodic drinking has been in decline in the Netherlands. The percentage of excessive drinking has declined by 25%, from 11,3% in 2001 to 8,5% in 2019. The number of heavy drinkers fell from 13,6% in 2001 to 8,5% in 2019, a decline of 38%.

Graph 2: decline of excessive drinkers (blue line) and heavy episodic drinkers (orange line) in the Netherlands



Source: [Central Bureau of Statistics](#)

Multi stakeholder approach to combat alcohol consumption is working

The long-term trend of declining excessive alcohol consumption does not come out of nowhere. The Dutch government, NGOs and the alcohol sector have a long tradition of working together in reducing excessive consumption and alcohol abuse. For example, since 2002 the Dutch Traffic Ministry, the Dutch Road Safety Association and the alcohol sector work together in the BOB-campaign, which aims **to promote a culture of don't drink and drive**. Since the start of the campaign, the percentage of people that exceeds the maximum legal blood alcohol concentration during traffic controls has been cut in more than half (from 4% in 2002 to 1,4% in 2017).

In 2018, the Dutch Ministry of Health and 70 organisations, including health NGOs, associations of medical professionals, the association of municipalities and economic operators in the alcohol sector signed the [National Prevention Agreement](#). One of the goals of this agreement is to reduce alcohol abuse. As part of this agreement, the brewing sector has committed itself to a variety of actions to stimulate responsible drinking. For example, the sector is working hard to make sure that every student association offers non-alcoholic beer to its members and to improve the image of non-alcoholic beer among students. This has resulted in 60% of student associations serving non-alcoholic beer, a number that continues to grow. This contributes to the change of culture that is necessary to reduce alcohol abuse among Dutch students.

2. Recommendations

Policy options should fit the national context

The development of declining alcohol abuse show that the approach of multi-stakeholder cooperation to reduce alcohol harm is working in the Netherlands. We therefore urge the WHO to maintain the possibility for governments and NGOs to pursue policy options that work in a given country, instead of focussing on a one-size-fits-all-solution for all countries. Each national context requires a different approach. Policy options that work in one country, might not work in others. The Global Alcohol Strategy should reflect this difference between countries, so that countries can adopt a policy that works best for them.

Non-alcoholic beer as part of the strategy

We think it is a missed opportunity that the Working document does not mention the availability of non-alcoholic alternatives to alcoholic drinks as part of the strategy to reduce



alcohol abuse. While alcohol consumption and excessive alcohol consumption continues to decline in the Netherlands, consumption of non-alcoholic beer in the Netherlands is rapidly increasing. Since 2010, the consumption of non-alcoholic beer has increased with 444%. More and more brewers have non-alcoholic beers in their product portfolios. Breweries have invested a lot of time and effort in improving the taste of non-alcoholic beer and in brewing more varieties of non-alcohol beers. This has improved the image of non-alcoholic beer as an alternative to alcoholic beer. In the coming years, brewers will continue to stimulate non-alcoholic beer as an alternative for alcoholic drinks and we expect that the upward trend of consumption of non-alcoholic beer will continue as a result. Acceptance by consumers of non-alcoholic beer (and wine and spirits) as a full alternative to alcoholic drinks and the greater availability of non-alcoholic beer, is an important asset in nudging consumers from alcoholic drinks to non-alcoholic alternatives. We urge the WHO to include non-alcoholic beer (and wine and spirits) in its strategy.

No inherent conflict between interests

The Working document states that there is an inherent conflict between the interests of **alcoholic drinks producers and the interests of public health. We don't agree with this statement.** As indicated above, the Dutch Traffic Ministry, the Dutch Road Safety Association and the alcohol sector joined forces to combat drinking and driving, leading to a reduction of driving under influence. It is also not in the interest of economic operators when people engage in hazardous driving behaviour. Secondly, the beer sector is partner of the Dutch government in the National Prevention Agreement. In this partnership we work together with all other stakeholders to promote responsible alcohol consumption and reduce problematic alcohol consumption and its negative impact on individual as well as society. So in the view of the brewing sector, there is no inherent conflict. Governments, stakeholders and the alcohol sector share the same goal: combatting alcohol abuse.

Conclusion

It's is of the utmost importance to combat alcohol abuse. People should refrain from excessive drinking and in certain circumstances they should not drink at all, for example when they're pregnant, when they're driving or when they're minors. But we should not forget that many people that drink, enjoy alcohol responsibly. The aim of the Global Strategy on Alcohol should therefore focus the *abuse* of alcohol. This goal is best achieved when governments, NGOs and companies work together.

Nepal Alcohol Policy Allianc

Country/Location: Nepal

Submission

- Cost-benefit analysis in LMIC's like Nepal needs to be the focus of the action plan, alcohol is often seen as an economic driver and the MS does not take into account the long term effects of alcohol in increasing NCD's. The policies are mainly influenced by looking at the short-term economic benefits through taxation rather than focusing on the overall wellbeing of its citizens.
- Ensuring greater focus on the SAFER (Strengthening restrictions on alcohol availability; Advancing and enforcing drink driving countermeasures; 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.) strategies to ensure that limited resources can be used to have the greatest impact on reducing harm.
- The alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The Action Plan must recognize their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy.
- 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.
- The action plan should promote collaborative efforts of MS and civil society especially inclusive of youth groups and women's groups to create a syngeneic effect to bring sustainable change in the community behaviour.
- The action plan should also set a threshold for a definite commitment from the MS to endorse the WHO Global Strategy and start performing to implement the provisions from the Global Strategy.

Attachment(s): 1

00458_85_napa-submission-who-gas.pdf



Nepal Alcohol Policy Alliance (NAPA)
NAPA Secretariat, Rabibhawan, Kathmandu, Nepal
cwinnepal1987@gmail.com
sumnima.cwin@gmail.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.

Nepal Alcohol Policy Alliance (NAPA) is a national network established in 2009 by the effort of civil society organisations working in human rights, gender equality, child rights, social justice, public health and consumer rights. It advocates in federal, province and local level for policies and their effective implementation to minimize the harms of alcohol use in Nepal through effective structures and mechanisms. It has been conducting studies on the impact of alcohol use in society through action research and is also campaigning against the harmful use of alcohol in collaboration with the community and stakeholders. It is working in coordination with the Government of Nepal, FORUT-Norway, the Global Alcohol Policy Alliance (GAPA), concerned Parliamentarian Committees, members of parliament and members of civil society with its mission to sensitise stakeholders including children and adolescents on harmful effects of alcohol in their physical and mental health, social fabric including livelihoods and to lobby and advocate for favourable policies supported by robust implementation plans for minimising the use and promotion of alcohol.

- Alcohol has a direct correlation between the rate of consumption and increased instances of gender-based violence including domestic violence and violence against children.
- Alcohol decreases the working capacities of youths and inhibits their creativity and potential
- Alcohol consumption decreases the overall productivity in LMIC and adversely impacts SDG 1. Alcohol leads to reduced investment in education by parents in LMIC and increases child neglect. (SDG 4)
- There have been several myths propagated and the misinformation about alcohol use has resulted in death, especially during the Covid-19 pandemic.
- While blatant commercial use, promotions by the social sector, sports and music endorsements, event sponsorship has escalated use of alcohol in youth affecting their health, behaviour and future, alcohol poisoning, after improperly distilled homemade methyl alcohol claims numerous lives yearly.
- In LMIC and in the South Asian Region, political parties while campaigning during elections lure the youth population using alcohol as a means of gaining their loyalty.

- Ineffective implementation of the policies and lack of robust monitoring mechanisms by MS, has resulted in easy availability of alcoholic beverages. Access to alcohol has increased massively while access to basic healthcare and other amenities are a grave challenge. Almost all shops including small shops have the availability of alcohol.
- Lack of political commitment to endorse the WHO Global Strategy by the MS has resulted in the delay in the endorsement of national policies and progressive amendment in the laws that control production, consumption and promotion of alcohol which causes irreparable damage to the wellbeing of the entire generation.
- However, with a strong commitment from all sectors, Nepal has excelled in strict zero-tolerance policy in enforcing drink driving counter measures and this can be an example in moving towards a comprehensive national policy to address all aspects of WHO 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. 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.

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 the resources required for action.
- The inclusion of an objective focusing on prevention and treatment capacity is an integral part of universal health coverage.

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

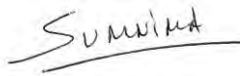
- Cost-benefit analysis in LMIC's like Nepal needs to be the focus of the action plan, alcohol is often seen as an economic driver and the MS does not take into account long term effects of alcohol in increasing NCD's. The policies are mainly influenced by looking at the short-term economic benefits through taxation rather than focusing on the overall wellbeing of its citizens.
- Ensuring greater focus on the SAFER (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.) strategies to ensure that limited resources can be used to have the greatest impact in reducing harm.
- The alcohol industry should not be placed in equal standing with international partners and civil society as the current working document does. The Action Plan must recognise their fundamental conflict of interest and vast track record of interference against effective implementation of the global strategy.
- 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.

- The action plan should promote collaborative efforts of MS and civil society especially inclusive of youth groups and women's groups to create a syngeneic effect to bring sustainable change in the community behaviour.
- The action plan should also set a threshold for a definite commitment from the MS to endorse the WHO Global Strategy and start performing to implement the provisions from the Global Strategy.

Thank you for your consideration.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Sumnima', with a horizontal line drawn underneath it.

Sumnima Tuladhar
National Coordinator,
Nepal Alcohol Policy Alliance (NAPA)
Secretariat, CWIN-Nepal
Rabhiwan, Kahmandu Nepal

Nepal Health Society

Department/Unit: *Health*

Country/Location: Nepal

URL: nepalhealth.org.np

Submission

1. Ensure bold targets and ambition with funding opportunity specially for developing and under developing countries high risk groups.
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.

Attachment(s): 0

New Zealand College of Public Health Medicine

Country/Location: New Zealand

URL: <https://www.nzcphm.org.nz/>

Submission

The New Zealand College of Public Health Medicine endorses the submission by Alcohol Healthwatch 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'.

In particular,

- We call for the urgent development of an international health treaty on alcohol control, similar to the Framework Convention on Tobacco Control, to support Member States in their actions to protect the health of their populations. Without urgent action of this nature, the ability, particularly of small states, to counter vested commercial interests is significantly reduced.
- We note the return on investment data for 'best buys' provided in the Working Document. We agree with Alcohol Healthwatch that the Action Plan should be based around the most effective evidence-based interventions identified in the SAFER guidance. Particularly with regard to the restriction of availability of alcohol, the international evidence is clear and consistent. Where restrictions are in place, alcohol use and related harms are reduced.
- Finally, we strongly support the suggestion that actions and indicators that explicitly address equity should be included in the action plan. Preventable harm from the misuse of alcohol amongst disenfranchised groups is a leading cause of health inequities. In New Zealand, for example, alcohol harm in pregnancy disproportionately affects Māori as well as the most deprived in the population.

Attachment(s): 1

00290_58_nzcphm-submission-to-who-dec-11-2020.pdf



The New Zealand College of Public Health Medicine (NZCPHM) is the professional body representing the medical specialty of public health medicine in New Zealand. We have 205 active members, including 185 fully qualified Specialists, with the majority of the remainder being advanced trainees in the medical specialty of public health medicine. Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM partners to achieve health gain and equity for our population, eliminating inequities across socioeconomic and ethnic groups, and promoting environments in which everyone can be healthy.

The New Zealand College of Public Health Medicine endorses the submission by Alcohol Healthwatch 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’.

In particular,

- We call for the urgent development of an international health treaty on alcohol control, similar to the Framework Convention on Tobacco Control, to support Member States in their actions to protect the health of their populations. Without urgent action of this nature, the ability, particularly of small states, to counter vested commercial interests is significantly reduced.
- We note the return on investment data for ‘best buys’ provided in the Working Document. We agree with Alcohol Healthwatch that the Action Plan should be based around the most effective evidence-based interventions identified in the SAFER guidance.¹ Particularly with regard to the restriction of availability of alcohol, the international evidence is clear and consistent. Where restrictions are in place, alcohol use and related harms are reduced.²
- Finally, we strongly support the suggestion that actions and indicators that explicitly address equity should be included in the action plan. Preventable harm from the misuse of alcohol amongst disenfranchised groups is a leading cause of health inequities. In New Zealand, for example, alcohol harm in pregnancy disproportionately affects Māori as well as the most deprived in the population.³

December 11, 2020

Contact: admin@nzcpbm.org.nz

¹ World Health Organisation, SAFER: Preventing and Reducing Alcohol-Related Harms brochure. Geneva: WHO, 2018.

(https://www.who.int/substance_abuse/safer/launch/en/)

² Anderson, P. & Baumberg, B. Alcohol in Europe: A public health perspective. London, UK: Institute of Alcohol Studies, 2006.

(<http://dse.univr.it/addiction/documents/External/alcoholineu.pdf>)

³ Ministry of Health. Tier 1 statistics 2016/17: New Zealand Health Survey. Wellington: MoH, 2017. (<https://www.health.govt.nz/publication/tier-1-statistics-2016-17-new-zealand-health-survey>)



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 healthy.³⁵
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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New Zealand Medical Association

Country/Location: New Zealand

URL: www.nzma.org.nz

Submission

The New Zealand Medical Association (NZMA) endorses the submission by Alcohol Healthwatch New Zealand (attached) 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'. Please refer to the two attachments.

Attachment(s): 2

00495_20_ahw-submission-to-who-working-document-dec-9-2020.pdf

00495_19_nzma-submission-on-who-action-plan-to-strengthen-implementation-of-the-global-strategy-to-reduce-alcohol-harms.pdf

13 December 2020

World Health Organization
By online submission

Working document for development of an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol

Dear Sir/Madam

The New Zealand Medical Association (NZMA)¹ endorses the submission by Alcohol Healthwatch New Zealand (attached) 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'.

Reducing the harm from alcohol is a core area of advocacy for the NZMA.² We have previously called for the development of an international health treaty on alcohol control, similar to the Framework Convention on Tobacco Control, to support Member States in their actions to protect the health of their populations.

Yours sincerely



Dr Kate Baddock
NZMA Chair

¹ The NZMA is New Zealand's largest medical organisation, with about 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. We recognise the principles of te Tiriti o Waitangi and the special obligations to Māori, particularly to ensure equity and active protection. Current disparities in health outcomes between Māori and non-Māori are unacceptable. The NZMA is committed to advocating for policies in health and the social and wider determinants of health that urgently address these disparities and contribute to equity of health outcomes.

² Reducing alcohol-related harm. NZMA Policy Briefing. May 2015. Available from <https://www.nzma.org.nz/policy-briefings/reducing-alcohol-related-harm>



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:

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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 healthy.³⁵
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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Country/Location: Estonia

URL: www.nordan.org

Submission

The Nordic Alcohol and Drug Policy Network wants to thank you for the opportunity to contribute to this consultation. We appreciate the process, and we agree on the basic elements and policy actions listed in the background document. We do want to add the following comments and suggestions:

FCAC

We appreciate the acknowledgement of the absence of "legally-binding regulatory instruments" at the international level and the need for "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". It is vital that with every step we take, we would move closer to a Framework Convention on Alcohol Control, which would take the reduction and prevention of alcohol-related harm to another level.

The role of the civil society

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."

While we fully agree that supporting and promoting "high-impact policy options" and monitoring "economic operators" is an integral part of civil society's role, it is not all and perhaps not even the main tasks of the civil society. It should also monitor government policies and actions and hold governments accountable. Civil society should be able to offer alternative policies for governments and the private sector. As a "third sector," it is not our purpose to partner with either government or business but to be able to monitor freely, and if necessary, give alternatives to both.

Addressing the problems that weaken the "best buys"

Alcohol is a regional, national and international problem. Action is needed at all levels. There are cross-border issues that limit a single state to deal with the alcohol problem within their country. Unhealthy downward tax competition and border trade between neighbouring countries weaken the effectiveness of pricing policies. Fear of – or real – losses in trade resulting from cross-border shopping are leading different countries to reduce, or refrain from increasing, alcohol taxes. The solution is in cooperation between countries and institutions like European Union, which should revise the rules for private import of alcoholic beverages. Without these international agreements, we see the States struggling with their national policies and best-buys are often undermined.

The working document, in our view, lacks a focus on cooperation between countries. At best it describes cooperation and collaboration in "experience sharing among countries" and "data collection". More is needed.

☐ Alcohol as a carcinogen and prenatal alcohol exposure

Understanding that neither this working document nor the final action plan is intended as a comprehensive overview of different alcohol-related harms, it should include a stronger rationale for the need for urgent and also specific action.

Prenatal alcohol exposure and foetal alcohol spectrum disorders (FASD) are not mentioned in this document. It might be argued that the paper considers it included with the mention of "harm to others" perspective. Still, the definition of the term doesn't clearly include it - "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)."

The awareness of the problems with prenatal alcohol exposure continues to be low, and the experience from countries globally show that the focus on dealing with this preventable, but life-long issue is weak. It needs special recognition and also asks for specific interventions, both in the prevention and treatment side. Merely hoping that this is something that is covered within the "harm to others" concept, is not enough. FASD needs more substantial attention within the WHO cooperation.

Protecting children from alcohol-related harm should be in the focus of this action plan. Children exposed to alcohol in family, as well as in utero exposure (FASD) is a serious issue all over the world and has strong links to lifelong problems not only to the individuals affected but for the whole societies.

We also see a problem of how alcohol as a risk factor for cancer is covered in the working document. "Alcohol's causal relationships with some types of cancer" sounds ambiguous and as such diminishes it as factual knowledge. This is also the only mention of cancer in this document, and in our view, it should have a much more prominent position. According to available national surveys and studies from the Nordic and Baltic region, most of our citizens are not aware of the fact that alcohol causes cancer. Evidence shows that only 20-40% of people are aware of that link. We do not have any reasons to believe that this low awareness would not also reflect the level of understanding among party politicians who are responsible for the national alcohol policies.

The evidence of alcohol and cancer link is much more substantial today compared to the launch of the WHO Alcohol Strategy in 2010. Still, there is evidence that the alcohol industry sometimes misrepresents or downplays evidence about the alcohol-related risk of cancer. That puts a special responsibility on our governments to react to the alcohol industry's misleading role and to make sure that consumers are aware of the carcinogenic risks of alcohol.

It is our view that alcohol's carcinogenic effect should be a much stronger argument in our national and international alcohol policy discussions and WHO's documents should encourage it.

☐ GAPA's key recommendations for the WHO decision to 'accelerate action to reduce the harmful use of alcohol 2022-2030'

We also express support for the key principles of the Global Alcohol Policy Alliance (GAPA). We join with GAPA requesting "WHO and Member States to consider strengthening the provisions of WHO Framework for Engagement with Non-State Actors (FENSA) to include specific reference to alcohol industry in relation to conflict of interest, and to improve the implementation of FENSA."

NordAN also joins GAPA in requesting WHO and Member States to place the need of low and middle-income countries for assistance in stemming the tide of alcohol to the forefront of the action plan. WHO needs to be resourced at all levels, including in regional and country offices, to be able to give substantial assistance to Member States to reduce alcohol harm through the implementation of SAFER including protection against conflict of interest.

☐ The role of the regional level

We wish to echo the concerns of European Alcohol Policy Alliance that there is no clear reference or actions directed to neither a regional political body, such as the European Union nor the WHO regional offices. 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.

☐ Exposure, not target group, of marketing and advertisement

NordAN also joins Eurocare in suggesting to change 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.'

Attachment(s): 0

Norwegian Cancer Society

Country/Location: Norway

URL: <https://kreftforeningen.no/>

Submission

Norwegian Cancer Society's comments for consideration in 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'

The Norwegian Cancer Society welcomes the opportunity to contribute to this consultation. We applaud the work done to prepare the working document.

As a cancer society dedicated to prevent and control cancer, we need to better address this risk factor and increase the awareness of the link between alcohol and cancer. Alcohol causes seven types of cancer (mouth, upper throat, larynx, oesophageal, breast, bowel, and liver) and there's no safe lower limit. Based on that knowledge European Code against Cancer states that "If you drink alcohol of any type, limit your intake. Not drinking alcohol is better for cancer prevention."

Alcohol use is one of the most important preventable risk factors for cancer along with tobacco use.

Alcohol's attributable contribution to cancer is not well recognised. Evidence shows that only 20-40 percent of the population in the Nordic countries are aware of the link. Most people believe they have a not-harming consumption and the myth about heart health from a glass of wine is still very much alive. Our governments have a responsibility to make sure that consumers are aware of the carcinogenic risks of alcohol and implement evidence based regulatory measures to reduce consumption and harm.

Since the endorsement of the Global Alcohol Strategy in 2010, alcohol as a risk factor for non-communicable diseases and alcohol policies have gained traction through the political declaration during the high-level meeting on NCDs in 2011 and the Global Action Plan for NCDs 2013 as well as being included in Sustainable Development Goal 3.5 and inherent in pursuing other SDGs including 3.4 for a reduction in premature mortality from NCDs. Positioning of alcohol within the NCD framework has strengthened the case for alcohol policy, expanded engagement of stakeholders, and helped elevate alcohol on the global policy agenda, particularly with half of all alcohol related deaths due to NCDs.

While these efforts have achieved some stalled increases in use and harm, the progress has been uneven and many countries will not reach the relative reduction in NCD-targets or the SDG goals. While the Global Alcohol Strategy is still useful, it requires updating to reflect developments the last decade.

The Norwegian Cancer Society would emphasize following in the working document:

Action 7 under action area 2: 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 including the link between alcohol and cancer.

We would also emphasize:

Action 2 under action area 1: 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.

Evidence on the cost-effectiveness of alcohol policy options and interventions exists in the revision of Appendix 3 to the NCD global action plan, from the Health Assembly in 2017.

The most cost-effective actions, or “best buys”, include increasing taxes on alcoholic beverages, enacting and enforcing restrictions on the physical availability of retailed alcohol and enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media. The transnational alcohol industries expansion of marketing in social media is of great concern.

While comprehensive sets of policies are most effective and ideal, a particularly powerful opportunity is presented by effective taxation of alcohol.

We suggest to underline the importance of the best buys and request that they be sufficiently highlighted in the ‘Key areas for global action’.

As recognised in the guiding principles of the Global Alcohol Strategy, public health 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. There is a fundamental conflict of interest between the alcohol industry’s interests and public health policy interests. We strongly support the inclusion of clear guidelines on managing conflicts of interest.

We support the statement asking for economic operators to refrain from policy interference

In the current document the economic operators are listed as stakeholders alongside civil society and other UN organisations. This is inappropriate. Given the conflict of interest and record of influence against effective policy, including in low- and middle-income countries, they should be addressed in a separate section with due regard to conflict of interest.

At no stage in the action points is there any mention of a role for the 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.

It should be a priority to strengthen engagement with other (non alcohol industry) stakeholders. NGOs are important allies and can reliably use evidence to inform communications and awareness campaigns to reduce harmful use of alcohol and to enhance the implementation of stricter policies and measures.

Attachment(s): 0

OIV

Department/Unit: *Director General*

Country/Location: France

URL: <http://oiv.int/>

Submission

Information should be based on sound scientific evidence to ensure that all the health consequences of alcohol consumption are considered, with the main objective of facilitating informed decisions on consumption.

The OIV suggests to include in the draft action plan the importance of the adoption of a training programme for education and prevention. Evidence-based knowledge and education of the general public, health and social policy professionals, as well as the relevant media, are prerequisites for the successful implementation of national alcohol policies.

Attachment(s): 1

00340_17_oiv-contribution-to-who-draft-action-plan.pdf

Contribution of the OIV

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.

OIV

The International Organisation of Vine and Wine (OIV) is a technical and scientific intergovernmental organisation, initially founded in 1924, and renewed in 2001. The OIV is composed by 47 Member States, they all belong to the WHO. One of the OIV core missions is to help protect the health of consumers and to contribute to food safety as stated in the Agreement of April 3rd 2001, Article 2.2. In particular: by specialist scientific monitoring, making it possible to assess the specific characteristics of vine products; by promoting and guiding research into appropriate nutritional and health aspects; by extending the dissemination of information resulting from such research to the medical and healthcare professional .

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:”*

General comments

The OIV thanks the WHO Secretariat for the opportunity to comment on the draft document for the action plan. The OIV, as an intergovernmental organisation, supports all actions which lead to reduce the Harmful Use of Alcohol.

The OIV considers that consumers should be fully informed about the characteristics and quality of what they consume and the consequences for their health of their consumption, in order to make informed choices. It seems necessary to exchange information and expertise in this areas of mutual interest of both Organisations.

Within this framework the OIV’s Strategic Plan 2020-2024, recently adopted by its 47 Member States, includes specific objectives (Axe III. A) to encourage research, collection and dissemination of scientific information on the effects of the consumption of wine, grapes and other vine-based products on health, together and in coherence with the WHO and other relevant organisations.

In addition, another objective is to identify and recommend research axes, in collaboration with the Food and Agriculture Organisation (FAO) and the WHO, on the health aspects, nutritional and functional properties and socio-behavioural factors of vine-based products.

The OIV is also committed to the SDGs, and at a broader level, its involvement in the SDGs is aligned with the Axes of the OIV Strategic Plan. In particular, Axis III *“Contribute to social development through vitiviniculture”* is aligned with SDG 3 *“Good health and Well-being”*.

The OIV looks forward to continuing and improving the fruitful collaboration with the WHO HQ in all subjects that fall within the competences of both our Organisations.

Specific comments

We would like to draw your attention on the following actions.

Challenges in implementation of the Global Strategy

Page 4, 3rd paragraph

The OIV supports this statement and proposes to add the following addition at the end of the sentence: *“The production of alcoholic beverages has become increasingly concentrated and globalized in recent decades, particularly in the beer and spirits sectors. On the other hand, the wine sector continuous to be a very fragmented economic structures.”*

Operational principles for global action

Page 9: Multisectoral action

Exceptionally the economic structure of the wine producing sector is evolving towards a more fragmented production. Causes can be found in sustained government policies oriented to ensure grape-growers to produce their own labels. In most cases these policies involve heavy regulation, supply and production limitations. Most producing countries belong to the International Wine and Vine Organisation (O.I.V.) an OIG that promotes resolutions on production and labelling standards. Considering the different economic structure of the different producing industries, the Multisectoral action need a definition of what is involved in this operational principle.

ACTION AREA 2: ADVOCACY, AWARENESS AND COMMITMENT

Proposed actions for the WHO Secretariat

Action 6: Develop the international standards for the 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 also consider ongoing work at international level on labelling. The OIV is currently working on an update of the OIV international standard for wine labelling

The work done by the Codex Alimentarius, in particular the Codex Committee on Food Labelling (CCFL), should be taken into account, considering the initial discussions on the labelling of alcoholic beverages (REP19/FL). A special attention should be given to the evolution of this group

ACTION AREA 5: KNOWLEDGE PRODUCTION AND INFORMATION SYSTEMS

The OIV and the WHO Secretariat are already collaborating on the data collection and analysis through the exchange and harmonisation of information on wine in particular. We would like to highlight the following points:

- **In the area of data collection and dissemination**

The draft action plan should also make recommendation to Members States and the WHO Secretariat to work towards a common methodology for the collection and analysis of relevant data to monitor and evaluate, for example, the unrecorded consumption

- **In the area of production and dissemination of knowledge**

International scientific cooperation in the analysis of alcohol consumption and its effects is needed to address these important and complex issues, in view of producing correct information and identifying the most effective measures and initiatives to reduce the harmful use of alcohol.

When analysing alcohol consumption, cultural norms and the specificity of the products consumed should be taken into account. The OIV, with its scientific delegates and experts appointed by its Member States, as part of its core mission, helps to protect the health of consumers and contribute to food safety (Agreement of April 3rd. 2001, Article 2.2). In this framework, the OIV promotes scientific research aimed at assessing the effects of wine consumption on health. The OIV recognises the need to strengthen international collaborative research as a valuable mechanism for advancing knowledge.

Proposed actions for the WHO Secretariat

Action 6 : The OIV suggests to modify the sentence as follows : “Continue and further develop collaboration with United Nations entities and other intergovernmental and international organisations on data collection and analysis as well as”

As already indicated above, the OIV already collaborates with the WHO by providing data on the level of wine consumption.

Suggestions for consideration

Information should be based on sound scientific evidence to ensure that all the health consequences of alcohol consumption are considered, with the main objective of facilitating informed decisions on consumption.

The OIV suggests to include in the draft action plan the importance of the adoption of a training programme for education and prevention. Evidence-based knowledge and education of the general public, health and social policy professionals, as well as the relevant media, are prerequisites for the successful implementation of national alcohol policies.

People Against Drug Dependence and Ignorance

Country/Location: Nigeria

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 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

Attachment(s): 1

00455_83_paddi-movendi-members-who-workingdoc-consultation.pdf



People Against Drug Dependence and Ignorance (PADDI)

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SUBMISSION – WHO CONSULTATION – WORKING DOCUMENT TO DEVELOP AN ACTION PLAN FOR IMPROVING WHO GAS* IMPLEMENTATION

People Against Drug Dependence and Ignorance (PADDI) Is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

People Against Drug Dependence and Ignorance is a Nigerian not-for-profit, non-governmental organization and committed to addressing the twin societal scourges of Ignorance and Substance abuse. The adverse impact of alcohol abuse on our country's developmental aspirations makes our organization desirous of the coming into being and Implementation of a WHO Global Alcohol Strategy

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

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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.

Thanks for your kind consideration and action

your truly,

for: **People Against Drug Dependence and Ignorance (PADDI)**

A handwritten signature in blue ink, reading "Eze Eluchie", written in a cursive style.

Eze Eluchie, Esq
Executive Director

Pernod Ricard

Department/Unit: *Headquarters*

Country/Location: France

URL: www.pernod-ricard.com

Submission

Pernod Ricard's motto is "Créateurs de Convivialité" : we therefore believe the best way for our consumers to enjoy our brands in the spirit of conviviality is to avoid harmful consumption of alcohol and drink moderately. Accordingly, we place a very high emphasis on responsible alcohol consumption in all our policies and actions. We firmly believe that, for those who choose to drink, they should always do so responsibly, consistently with the official drinking guidelines in their national context.

We do believe companies like ours have a positive role to play, as it has been recognized in UN SDG, notably under SDG #17 on partnerships. We hope such a role will be recognized in the future WHO action plan.

We call upon the WHO in formulating their proposals for tackling harmful alcohol consumption, to always allow for differentiated solutions to fit with the national context.

We call on the WHO to always consider the right policy mix, and not place excessive emphasis on purely regulatory approaches. We respectfully suggest the WHO to look into alternative ways to change consumer behaviour.

In our view, a reasonable level of regulation & taxation of alcohol should always be accompanied by education and awareness initiatives targeting vulnerable or at risk population groups.

As a company, we are trying to contribute to this effort in reducing harmful alcohol consumption, in a variety of ways :

- training our own employees on the risks of harmful alcohol consumption
- taking steps to ensure our marketing does not encourage harmful consumption of alcohol, through our 15-year old Code of Commercial Communications and its unique governing body, the Responsible Marketing Panel, through appropriate training for our marketing staff, through full implementation of the IARD commitments with the social media platforms, known as Digital Guiding Principles
- contributing to many industry programmes to reduce harmful consumption around many countries
- developing our own programmes to achieve that goal, notably our flagship initiative Responsible Party, which has demonstrable positive results for our target audience

As a company, we want to continue playing our part in addressing harmful alcohol consumption, knowing that industry can indeed contribute to the public health effort, alongside all other actors, supporting governments, communities, NGOs etc. We hope the WHO can encourage us and all like-minded companies along this path, to rally as many other alcohol industry players as possible around this common cause.

Attachment(s): 1

00432_67_submission-pernod-ricard-to-who-consultation-alcohol-strategy-2020-12.pdf

Contribution to WHO consultation on Draft Action Plan to implement the Global Alcohol Strategy

Public Health concerns around alcohol consumption have always been an important issue for Pernod Ricard. This is the reason why we wanted to contribute ideas and thoughts to the World Health Organization's consultation on an action plan to implement the global strategy to reduce the harmful use of alcohol, based on our experience in these matters. Our motto is "Créateurs de Convivialité" : we therefore believe the best way for our consumers to enjoy our brands in the spirit of conviviality is to drink moderately. Accordingly, we place a very high emphasis on responsible alcohol consumption in all our policies and actions. We firmly believe that, for those who choose to drink, they should always do so responsibly, consistently with the drinking guidelines in their national context.

We deem ourselves to be a consumer-centric company, and we believe consumers are increasingly looking for healthier lifestyles, where moderate alcohol consumption can be a source of enjoyment.

Consumers are looking for more sustainable lifestyles and wellbeing. They tend to consider and scrutinise more the impact of their daily choices, and are more willing to embrace ways of consuming that are less harmful to them and the world. The younger generations are more focused on health, they increasingly look for healthy convivial occasions, and to avoid unhealthy activities in general such as excessive drinking. They aspire to actively do good and this aspiration for active engagement results in growing demand for increased transparency from business. Around 90% of consumers feel that companies / brands have a responsibility to take care of the planet and its people, and it is important that the companies and brands they buy from behave in a way that they consider ethically sound¹. The #1 UN SDG that people consider as being the most important for companies to work towards, in all countries, is #12 - ensure responsible consumption and production. **We do believe companies like ours have a positive role to play, as it has been recognized in UN SDG, notably under SDG #17 on partnerships. We hope such a role will be recognized in the future WHO action plan.**

Beyond this mega trend, we are also very much conscious that cultural and social norms will vary between countries, on whether to drink alcohol, which categories or brands drinkers will favor and how they want to consume alcohol. Recognizing that drinking patterns are very different around the world, we operate a decentralized business model, with a specific product offering for different countries and cultures. **We call upon the WHO in formulating their proposals for tackling harmful alcohol consumption, to always allow for differentiated solutions to fit with the national context.**

Not all regions of the world witness the same positive trends, but we note that there are encouraging signs that harmful alcohol consumption is generally decreasing, as the WHO working document points out. For instance, the latest European School Survey Project on Alcohol and Other Drugs (ESPAD) report

¹ <https://intelligence.wundermanthompson.com/trend-reports/the-new-sustainability-regeneration/#:~:text=The%20New%20Sustainability%20focuses%20on,mindful%20shopping%20to%20natural%20wellbeing>

showed a steady general decrease in both lifetime and 30-day use of alcohol, since 1995, for teenagers in 35 European countries.

However, **more needs to be done, and our company and our industry want to continue playing a positive part in accelerating these trends.** To achieve proper results, effective policy tools are required. Alcohol production, sale and consumption do need to be properly regulated. As a company, we of course comply with each and every law that is applying to our business. Further, we do work with public authorities in several countries to improve full enforcement of these laws by the broader public, whether they relate to legal drinking / purchasing age, drink & drive limits etc.

All policies should be evidence based. However, **evidence based does not mean relying solely on a theoretical study, but looking at real life conditions in each country to determine which policies work and which do not.** In that sense, national and local data collection on drinking patterns and harms require particular efforts and attention. Having access to facts and data is the prerequisite to relevant initiatives (regulatory and non-regulatory) that do address locally relevant needs.

Empirical observation shows **prohibitions and excessive supply restrictions have social and health impacts that contradict the objectives they seek to fulfil.** Restricting the supply of legal alcohol shifts demand towards illicit alternatives and incentivises illicit suppliers to enter the market. This was seen in countries that implemented dry laws in the wake of the COVID19 pandemic, such as India where customs and police officers reported an increase in demand and seizure of illicit alcohol,² and also South Africa,³ Panama,⁴ Mexico⁵ and Colombia.⁶ In Kerala, India, Finance Minister T.M. Thomas Isaac is reported to have said that illicit supply networks had taken up the demand for alcohol and a “social disaster” loomed if the ban continued.⁷

Illicit alcohol containing toxic chemicals and produced with a disregard for safety and sanitary regulations has caused many deaths in 2020, well reported in the media. Supply restrictions also led to consumers looting and panic buying, contradicting social distancing guidelines. In South Africa, Revenue Service Commissioner, Edward Kieswetter is reported to have said that the ban allowed illegal operators to gain a foothold in the market, who are now embedded in the supply chain and marketing themselves to previously honest drinkers, and it will take years to reverse the impact.⁸ Even a

² <https://www.indiatoday.in/business/story/coronavirus-india-lockdown-sends-grey-market-booze-prices-soaring-1667077-2020-04-15>

³ <https://www.thedrinksbusiness.com/2020/09/tackling-illicit-alcohol-trade-in-south-africa-critical-to-economic-recovery/#:~:text=Before%20coronavirus%2C%20the%20South%20African,a%20year%20to%20illicit%20trade.&text=In%202019%2C%20the%20alcohol%20sector,estimated%20to%20lose%20around%20R6.https://www.dailymail.co.uk/news/article-8355213/Fourteen-people-die-ten-fighting-lives-drinking-home-brew-South-Africa.html>

⁴ <https://www.laestrella.com.pa/nacional/200507/alcaldia-panama-acogera-levantamiento-ley-seca>

⁵ <https://laverdadnoticias.com/mexico/Mueren-189-personas-por-consumo-de-alcohol-adulterado-de-mayo-a-junio-20200614-0103.html>
<https://www.sinembargo.mx/22-09-2020/3864425>

⁶ https://www.eltiempo.com/bogota/coronavirus-en-bogota-medicina-legal-declara-alerta-epimediologica-por-muertes-por-metanol-518404?utm_medium=Social&utm_source=Twitter

⁷ <https://www.thehindu.com/news/national/kerala/ban-on-liquor-sale-to-continue-for-now/article31491793.ece>

⁸ <https://www.bloomberg.com/news/articles/2020-09-07/illegal-traders-embedded-after-south-africa-s-booze-tobacco-ban>

temporary supply restriction or ban, leaves long lasting consequences as habits form and illegal producers enter the market for the long term, impacting public health and government revenue streams.

Taxes collected on alcohol are an important source of revenue for many governments, enabling them to pay for a variety of public services, many of which are unrelated to alcohol consumption or abuse. Several countries noted the drop in revenue during the pandemic including India,⁹ South Africa,¹⁰ Australia¹¹ and Kenya.¹² However **sudden increases in taxes on legal alcohol has a similar impact to a ban, increasing the attractiveness of illicit product as the price of legal alcoholic beverages increases.** It is for this reason that an increase in excise tax on alcohol does not always increase revenue collected because illegal sellers do not participate in the tax system. Companies such as ours, who pay significant levels of taxes around the world, share a mutual interest with governments in counteracting the illicit market for alcohol and we welcome the opportunity to work with governments to develop effective policies in this area.

Therefore, **we call on the WHO to always consider the right policy mix, and not place excessive emphasis on purely regulatory approaches. We respectfully suggest the WHO to look into alternative ways to change consumer behaviour.**

In our view, a reasonable level of regulation & taxation of alcohol should always be accompanied by education and awareness initiatives targeting vulnerable or at risk population groups.

As a company, we are trying to contribute to this effort, in a variety of ways, as described below.

Sustainability & Responsibility strategy - as a responsible company, we want to ensure that our brands are enjoyed moderately and responsibly – in a way that brings people together and that doesn't cause harm individuals and our communities. **Reducing harmful drinking is core to our Sustainability & Responsibility strategy.**

Employee ambassadors – Pernod Ricard believes that education and targeted preventive action on the ground are an effective way of tackling the harmful use of alcohol. This starts with our employees. We have developed this year an internal digital training on alcohol and responsible drinking, translated into 21 languages and compulsory for all our employees worldwide. This training embeds the Group's Global Responsible Drinking Policy ensuring that all employees understand their responsibilities and Pernod Ricard's expectations of them. We have shared this training to the wider public on the EducateAll platform, a partnership between Edapp and UNITAR, to help people understand what alcohol is, how it can affect you and what responsible drinking really means.

Responsible marketing – we are taking steps to ensure our marketing does not encourage harmful consumption of alcohol. This pertains to our core role as alcohol manufacturer and marketer. We have a long-standing policy on ethical marketing: **in 2005, we launched our first internal Code for**

⁹ <https://www.bloomberg.com/news/articles/2020-04-28/alcohol-spat-shows-india-states-battling-modi-for-virus-billions>

¹⁰ <https://www.thedrinksbusiness.com/2020/09/tackling-illicit-alcohol-trade-in-south-africa-critical-to-economic-recovery/>

¹¹ <https://www.afr.com/politics/federal/covid-19-shutdowns-hit-alcohol-tax-take-20201009-p563km>

¹² <http://venturesafrica.com/kenya-alcohol-ban-cost-billions-thousands-jobs-three-months/>

Commercial Communications with a dedicated Control Panel made up of 6 people independent from the marketing function they are controlling. These people decide whether ads are compliant and report monthly to the Group Executive Committee. All major marketing campaigns are subject to pre-vetting, as well as new product launches, sponsorships or websites for example. The Panel adjudicated on more than 400 advertising campaigns in 2020, of which approx. 10% were vetoed or required changes before publication.

We also believe that training our people is a way to contribute to the effort and we are reaching annually around 3000 people with physical or digital trainings on ethical commercial communications. The increase in digital marketing and the lockdown conditions enabled us to roll out a Massive On-Line Training Course in April 2020 in 8 languages, we have now trained nearly 70% of this population and aim 100% completion by June 2021

In parallel, **we have a long-time policy of adherence to industry standards.** We ensure our ads are placed in media where 70 % of the audience is of the legal drinking age. We are implementing the commitments taken by all IARD member companies with social network platforms to ensure all our branded advertising assets on social media feature 5 safeguards to ensure our marketing does not inadvertently entice harmful alcohol consumption or youngest consumers. These prevention components known as the Digital Guiding Principles are embedded in the Code for Commercial Communications and mandatory for all digital media owned by Pernod Ricard. We commit to fully comply by 2024 and have by then the following in place in all social media platforms:

- A Responsible Drinking Message: Reminding users to drink responsibly, e.g.: “Enjoy Responsibly” or “Drink with moderation
- An age affirmation mechanism: Restricting profiles so they are only visible to those who declare they are over the legal drinking age.
- A forward Advice Notice : Reminding users not to forward content to anyone.
- An “official profile” badge or statement: Verifying to their social media pages so users know it’s the official brand page.
- Community guidelines on User Generated Content Policy : Sharing their policies with users regarding content that users might post or share on the brand page

Finally, we ensure marketing is targeted to the right audiences and have efficient policies with white and blacklists of media where our ads can or cannot be placed.

In-country initiatives – **Pernod Ricard also contributes to more than 150 responsible drinking initiatives worldwide, often in partnership with our peers and other external partners.** The majority of our interventions address heavy episodic drinking, underage drinking and drinking and driving, and promote the moderate consumption of alcohol. Our approach builds on the strength of our decentralized business model. We recognize that different cultures, religions and societies require different solutions within their local context. We believe in partnership as behaviour change cannot be achieved by us alone.

Responsible Party – **Pernod Ricard’s own flagship programme is run in partnership with the Erasmus Student Network to reduce binge drinking amongst students.** Since its inception in 2009, the program has reached over 470,000 students in 33 countries. Its scientific evaluation demonstrates that the

programme is effective in raising awareness of the risks of binge drinking and in reducing harm during the parties.

Partnerships – Pernod Ricard also contributes to many responsible drinking initiatives through our industry associations. For example, we contribute to a digital underage education programme in the USA, managed by the Foundation for Advancing Alcohol Responsibility. It is called “Ask, Listen and Learn”, for kids ages 9-13, their parents and educators. In 2019, the programmes reached 900.000 pupils, as well as 700.000 educators.

Cool Teens is a similar programme in India that Pernod Ricard supports. It seeks to help teenagers to learn more about alcohol and life skills so they can make better informed decisions. Since 2015, the programme has reached 175,000 students across 9 States in India to build awareness and capacity on the harmful effects of alcohol abuse.

In Russia, our industry association partners with the Moscow Automobile and Road Construction State Technical University to train young drivers on the risks of drinking and driving in a driving school setting. After a successful pilot in 2013, Autosobriety is now running in over 14 regions in Russia in more than 230 driving schools.

In conclusion, as a company, we want to continue playing our part in addressing harmful alcohol consumption, knowing that industry can indeed contribute to the public health effort, alongside all other actors, supporting governments, communities, NGOs etc. We hope the WHO can encourage us and all like-minded companies along this path, to rally as many other alcohol industry players as possible around this common cause.

About Pernod Ricard

Pernod Ricard is the No.2 worldwide producer of wines and spirits with consolidated sales of €€8,448 billion in the fiscal year ended 30th June 2020. Created in 1975 by the merger of Ricard and Pernod, the Group has developed through organic growth and acquisitions: Seagram (2001), Allied Domecq (2005) and Vin&Sprit (2008). Pernod Ricard’s brands are distributed by its own salesforce in 73 markets. The Group’s decentralised organisation empowers its 19,000 employees to be true on-the-ground ambassadors of its vision of “Créateurs de Convivialité.” As reaffirmed by the Group’s three-year strategic plan, “Transform and Accelerate,” deployed in 2018, Pernod Ricard’s strategy focuses on investing in long-term, profitable growth for all stakeholders. The Group remains true to its three founding values: entrepreneurial spirit, mutual trust, and a strong sense of ethics. This is illustrated by the 2030 Sustainability and Responsibility roadmap supporting the United Nations Sustainable Development Goals (SDGs), “We bring good times from a good place.” In recognition of Pernod Ricard’s strong commitment to sustainable development and responsible consumption, it has received a Gold rating from Ecovadis and is ranked No. 1 in the beverage sector in Vigeo Eiris. Pernod Ricard is also a United Nation’s Global Compact LEAD company. Pernod Ricard is listed on Euronext stock exchange and is part of the CAC 40 index.

Polish Brewers Association - ZPPP Browary Polskie

Country/Location: Poland

Submission

About The Union of Brewing Industry Employers – Polish Breweries (pol. Związek Pracodawców Przemysłu Piwowarskiego – Browary Polskie)

The Union of Brewing Industry Employers – Polish Breweries is an organization that brings together leading beer producers in Poland. It shares its expertise and advises members on market regulations and obligations of market players. Promoting the positive image of the brewing sector, it fosters cooperation to support the drinking culture and responsible alcohol use.

The Union of Brewing Industry Employers – Polish Breweries has been the member of the European brewing industry organization - The Brewers of Europe since January 2004.

Consumption trends in Poland

Polish beer market can be described as stable and saturated with per capita consumption at 98-99 l/year since 2012.

However, the consumption of alcoholic beer is going down in Poland - in 2019 Poles consumed nearly 0.6 million HL of alcoholic beer less than in 2018. They are less keen to drink traditional lagers (with alcohol content of 0.5-6.1%) which went down by 2.7%.

In addition to that, experts have been witnessing a downward trend in the average alcohol content in beer sold in Poland - its value has been regularly declining for several years. In 2019, the volume of pure alcohol sold in beer dropped by 1.6% year-to-year, while sales volume dropped only by 0.5%. Between 2017 and 2019 the volume of pure alcohol sold in beer dropped by 3%. This is the after-effect of several trends:

- a. First of all, strong beers (with alcohol content above 6.1%) have been losing their market share for several years and in 2019 their sales went down by 3.9% (as compared to 2018). This was a next consecutive year of declining market share of this type of beer in Poland. In 2018 its share dropped by 0.2% after 6% decline in 2017.
- b. Secondly, non-alcoholic beer has consolidated its market position enough to be classified as a separate, strong category in its own right and became a regular fixture on Polish market. Currently it accounts for approx. 5% of the beer market, and 6% of the beverage category. A comparison of qualitative data for the segment with neighbouring markets reveals that Poland is right halfway between Russia and Germany, holding 4.7% of market share versus 7.5% for Germany and 2.3% for Russia. Non-alcoholic beer won't stop there. In 2019 sale of non-alcoholic beer in Poland increased by ca. 80% year-to-year. It was the highest growth of this category in EU. Previously, in 2018, sale of this type of beer in Poland had similar positive dynamic – ca. 80% y-t-y.
- c. Weighted average alcohol content in alcoholic beer sold in Poland gradually decrease – in 2017 it was 5.37%, in 2018 – 5.33%, in 2019 – 5.27%. This decline reflects shift towards low-alcoholic beers

(e.g. radlers), beer specialities and generally beer products chosen for their flavour features rather than alcohol content as well as shrinking market share of strong beers mentioned above.

Brewers are monitoring the growing consumer interest in the lower and non-alcohol category and respond to that by expanding their range - we see a number of non-alcoholic novelties every year.

The role for lower alcohol beverages

Polish authorities, as in all other European countries, treat different alcoholic beverages differently, whether it be through the fiscal system, or marketing freedoms. 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 and non-alcoholic beer, 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 into alcohol consumption models in Poland reveals that various alcoholic beverages are consumed with different frequencies, at different occasions and in different quantities, what carries specific risks and health impacts. Poles usually opt for beer and they usually drink from two to three 0.5 litre beers on a single occasion. Such quantities translate into consumption of 40 to 60 grams of pure alcohol on a single occasion, or from 4 to 6 standard units of alcohol. In case of wine, an average consumer drinks four 100 ml glasses on a single occasion, what corresponds to approx. 40 g of pure alcohol (4 units of alcohol). In case of vodka, drinking occasions usually involve much larger quantities of ethanol - eleven 30 g glasses on average, what corresponds to 94 to 110 g of pure alcohol (from 9.4 to 11 units of alcohol). It should be stressed, that children follow drinking patterns demonstrated by adults. Results of ESPAD survey conducted on minors since 1995 reveal a downward trend in beer and wine consumption that has continued for more than a dozen years. Meanwhile, a rise in vodka consumption among older students (17-18 years) has been visible since 2003.

Drinking patterns of various types of alcohol determine the potential degree of related hazards and health risks. Alcohol policy should put the spotlight on eliminating at-risk and harmful drinking, which are directly responsible for damage to health and the society at large. 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.

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 the representatives of drinks sectors from discussions on public health policy. However, there is no inherent conflict between the brewers' interests and those of public health. 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 valuable to the decision-making of governments.

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 nonalcoholic 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. Polish breweries associated in The Union of Brewing Industry Employers have actively contributed to the achievement of this commitment. All of them have fully implemented its provisions by the end of 2019. Information about the ingredients and calories content is now available on the label, alongside links to websites where the comprehensive list of nutritional values has been published for consumers. It is worth to mention that members of The Union of Brewing Industry Employers have all together ca. 80% stake in Polish beer market which makes their concerted efforts highly impacting local market and an example to follow for other brewers (e.g. placement of voluntary responsibility messages on packaging launched by members of The Union of Brewing Industry Employers).

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.

Impact of COVID crisis on the brewing sector

The pandemic has destabilized the beer market in Poland. Significant drop in sales has been observed in June and July – typically months of higher consumption. Beer is consumed in social settings and the full or partial closure of bars and restaurants, combined with further restrictions on social interactions, lack of sport and culture events, and breakdown of international tourism resulted in the total drop in consumption of 3% in the first 3 quarters of 2020 (as compared to Jan.-Sep. 2019). The data mentioned above doesn’t cover a second wave of pandemic related restrictions which have been introduced as of 24th of October and still go on. One of the results of these restrictions is effective ban on sale of alcohol by bars, restaurants, etc. In case of retail, sale of alcoholic beer declined by 2.3% while sale of non-alcoholic beer increased by almost 20% from January to October 2020 y-t-d.

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.

Attachment(s): 1

00402_51_who-consultation-zppp-browary-polskie.pdf



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In addition to that, experts have been witnessing a downward trend in the average alcohol content in beer sold in Poland - its value has been regularly declining for several years. In 2019, the volume of pure alcohol sold in beer dropped by 1.6% year-to-year, while sales volume dropped only by 0.5%. Between 2017 and 2019 the volume of pure alcohol sold in beer dropped by 3%. This is the after-effect of several trends:

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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.

Polish Spirits Industry

Country/Location: Poland

URL: <https://zppps.pl/en>

Submission

Polish Spirits Industry comments in public consultations of the Draft Action Plan to Implement the Global Strategy to Reduce harmful use of alcohol.

Polish Spirits Industry represents spirits industry in Poland and for over 12 years runs educational campaigns aiming at reducing harmful alcohol consumption and building responsible consumer culture. We cooperate with municipalities, social experts and organizations to tackle irresponsible behaviours and raise awareness on possible harms coming from alcohol consumption.

In our opinion all efforts of policy makers should focus on reducing harmful alcohol consumption, but not consumption per capita. If harmful consumption declines, per capita consumption may also decline. However, per capita alcohol consumption is neither the problem, nor should it be the target. Both documents, action plan and the Global Strategy should be uniform in terminology, but also objectives. For example in Poland 18,6 % of citizens consume around 70% of consumed alcohol, meaning over 6 l 100% alcohol per capita annually (source PARPA). 81,4% of Poles, the vast majority, behave responsibly. Consequently policies should focus on the small group – 18,6%, that need support from the state to change their behaviour, meaning tackle harmful alcohol consumption.

Also governments should adopt evidence-based, proportionate and time-bound policies, that reduce harmful use of alcoholic beverages, tailored to the conditions in a given country. Therefore the action plan should not focus on promoting SAFER initiative, but present a wide spectrum of possible policies included in the Global Strategy. Focus on very limited “best buys” is not always the best solution in specific environment of a Members State.

Taking into account Polish experience in tackling harmful alcohol consumption, economic operators should be included in the whole country plan for reducing harmful use of alcohol. For example in Poland a big emphasis was put on tackling drink driving. Joint effort of policy makers, police, but also alcoholic beverages producers, who launched numerous campaigns in TV and among customers, proved that synergy makes good results. In Poland the number of road accidents with drunk drivers falls every years, it has been reduced from 4 524 in 2010 to 2 717 in 2019 (source: Police reports) – this is a significant change. Polish Spirits Industry also conducts activities aimed at raising awareness among pregnant women about harmful alcohol influence on their unborn children. Campaign “Better start for your child” run for over a decade together with medical staff (gynaecologists and midwives) and activities of state agencies and other responsible operators bring satisfactory results – in Poland the number of women declaring consuming alcoholic while pregnant dropped from 10,1% in 2013 to 4,84% in 2017 (source: Chief Sanitary Inspection). We also observe stable and promising trends in decreasing alcohol consumption among teenagers and dropping a percentage of them who declare alcohol availability as easy (source: ESPAD 2019). Polish Spirits Industry supports this positive changes by workshops for sellers prepared in cooperation with local governments and police. There is no reason to prevent economic operators to cooperate with state and social partners in raising awareness among society, especially

that “the importance of pursuing whole-of-government and whole-of society approach” has been recognized in the 2018 UNPD. To summarize economic operators should not be excluded from the action plan.

Attachment(s): 1

00195_18_polish-spirits-industry-in-who-consultations-draft-guidlines.pdf



PPS/91/12/2020

Polish Spirits Industry comments in public consultations of the Draft Action Plan to Implement the Global Strategy to Reduce harmful use of alcohol.

Polish Spirits Industry represents spirits industry in Poland and for over 12 years runs educational campaigns aiming at reducing harmful alcohol consumption and building responsible consumer culture. We cooperate with municipalities, social experts and organizations to tackle irresponsible behaviours and raise awareness on possible harms coming from alcohol consumption.

In our opinion all efforts of policy makers should focus on reducing harmful alcohol consumption, but not consumption per capita. If harmful consumption declines, per capita consumption may also decline. However, per capita alcohol consumption is neither the problem, nor should it be the target. Both documents, action plan and the Global Strategy should be uniform in terminology, but also objectives. For example in Poland 18,6 % of citizens consume around 70% of consumed alcohol, meaning over 6 l 100% alcohol per capita annually (source PARPA). 81,4% of Poles, the vast majority, behave responsibly. Consequently policies should focus on the small group – 18,6%, that need support from the state to change their behaviour, meaning tackle harmful alcohol consumption.

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Polish Vodka Association

Country/Location: Poland

Submission

- 1.The Polish Vodka Association is an organization whose one of the most important goals is to promote the culture and tradition of responsible alcohol consumption.
- 2.Our campaign ("I swim without alcohol in my blood") adapted the profile of activities to our market, which shows that actions against harmful and irresponsible consumption of alcohol must be adapted to local needs and the local market.
- 3.Education is necessary, but let's remember that different traditions of alcohol consumption exist in almost every country and are part of its heritage. It is therefore necessary to fight harmful alcohol consumption, and not per capita consumption
- 4.There is no reason to prevent economic operators to cooperate with state and social partners in raising awareness among society.

Attachment(s): 1

00305_68_who-pva-statement.pdf

Warsaw, 4 December 2020

**Polish Vodka Association statement in public consultations of the Draft
Action Plan to Implement the Global Strategy
to reduce harmful use of alcohol.**

The Polish Vodka Association is an organization whose one of the most important goals is to promote the culture and tradition of responsible alcohol consumption. From the beginning of our activity, we have been working in this direction. Our flagship campaign is the "I swim without alcohol in my blood (Pływam bez promili)" campaign, the 14th edition of which was completed in August this year. Our campaign is based on extensive cooperation with various organizations, such as: Water Rescue Organisation, Polish Sailing Association, Polish Canoe Federation, Polish Angling Association. We are supported by the River Police and great sportsmen - ambassadors of our campaign.

Since 2007, WOPR (Water Rescue Organisation) has been actively participating in the implementation of the campaign "I swim without alcohol in my blood", which, with the support of the media, promotes the principles of safe rest by the water on a large scale.

This year's campaign "I swim without alcohol in my blood" is the 14th edition of this extremely necessary educational program, which shapes the appropriate attitude of Poles in the implementation of safe activities on the water.

The campaign reaches the audience through eye-catching infographics, sports events, local initiatives, meetings, interesting presentations and interviews. Through such actions, awareness of responsible rest by the water is growing, and most importantly, the way we think and perceive the issue of safety and anticipating threats changes. The idea of the campaign attracts more and more people, including many organizations, associations and celebrities, who by joining the campaign contribute to the promotion and expansion of the campaign's reach, which will result in even greater success in subsequent editions.

WOPR would like to express the hope that the social campaign "I swim without alcohol in my blood" will be initiated as every year and will remain an excellent opportunity to continue cooperation with the Polish Vodka Association.

(opinion of the Water Rescue Organisation)

In Poland, swimming after drinking alcohol is a problem, but thanks joint efforts of our organisation, water organisations, alcoholic beverages producers and police awareness of the problem is increasing.

Our campaign adapted the profile of activities to our market, which shows that actions against harmful and irresponsible consumption of alcohol must be adapted to local needs and the local market.

Educational activities on responsible alcohol consumption are also carried out by the Polish Vodka Museum, where at the end of each visit, each guest receives knowledge on this subject. This topic is closely related to the presentation of the history and tradition of our national Polish Vodka drink.

Education is necessary, but let's remember that different traditions of alcohol consumption exist in almost every country and are part of its heritage. It is therefore necessary to fight harmful alcohol consumption, and not per capita consumption. PARPA reports that in Poland 18.6% of people are responsible for the consumption of 70% of alcohol. And it is they who should be supported by the actions of the state to change their behaviour. 81.6% of Poles consume alcohol responsibly.

The activities of the Polish Vodka Association and other industry organizations promoting responsible alcohol consumption are not possible without cooperation with economic operators, another organisations, experts and policy maker. Therefore, we believe that excluding economic operators from the dialogue on this subject is counter-productive and limits the possibilities of conducting activities for responsible alcohol consumption.

There is no reason to prevent economic operators to cooperate with state and social partners in raising awareness among society.

Portman Group

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

URL: <https://www.portmangroup.org.uk/>

Submission

Portman Group response to WHO consultation on draft action plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol

Executive Summary

1. The Portman Group welcomes the opportunity to respond to the consultation aiding the development of an action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol, which is an area of primary focus to us as the UK alcohol industry regulator and social responsibility body committed to promoting responsible drinking.
2. We are responding from the perspective of the UK market as an example of industry best practice and the substantial progress that has been made to tackle the harmful use of alcohol in the country. This has been achieved, in part, through the ongoing success of voluntary cross-industry initiatives as well as public-private partnerships implementing public health initiatives.
3. Whilst there is more work to be done, the progress made so far in tackling alcohol-related harm and ensuring that the moderate majority of consumers drink responsibly should be celebrated. This also reinforces the need for the Global Strategy to focus on reducing harmful alcohol use rather than unhelpfully diluting its focus on overall consumption and alcohol use per se, which may undermine the commitment of the strategy to a harm reduction approach.
4. The success of voluntary measures, combined with a variety of initiatives from the UK Government to tackle alcohol-related harm, also underscores that the action plan should recognise the broad suite of policy options and interventions included in the Global Strategy for reducing harmful alcohol use, rather than prioritising a narrower set of restrictive policies under the SAFER initiative.
5. The success of industry initiatives also demonstrate that the sector has a serious commitment to tackling harm in the UK and across the world and should continue to be seen as an active and willing partner as part of a 'whole-of-society' approach to tackling harmful alcohol use, which should be reflected in the Global Strategy.

Attachment(s): 1

00196_19_portman-group-submission-to-draft-action-plan-on-who-global-strategy-on-alcohol-december-2020.pdf

Portman Group response to WHO consultation on draft action plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol



Executive Summary

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5. The success of industry initiatives also demonstrate that the sector has a serious commitment to tackling harm in the UK and across the world and should continue to be seen as an active and willing partner as part of a 'whole-of-society' approach to tackling harmful alcohol use, which should be reflected in the Global Strategy.

The Portman Group

6. Founded in 1989, the Portman Group is world leading as the first alcohol industry self-regulator. We are committed to moderation and promoting a sensible relationship with alcohol among those who choose to drink in the UK. We've worked hard to act as a bridge with industry and UK Government to increase awareness and raise standards. This has helped contribute to a downturn in misuse.
7. The Portman Group operates the [Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks](#) and the [Code of Practice on Alcohol Sponsorship](#). They ensure that alcohol is marketed in a socially responsible way, only to those aged 18 and over, and in a way that does not have particular appeal to vulnerable consumers.
8. The Independent Complaints Panel applies the Code, which has led to more than 160 irresponsible and inappropriate products either being re-branded or removed from the market, in turn driving industry changes and protecting consumers.

9. The Code is regularly updated to reflect societal changes. The most recent Code was published in March 2019 following a formal consultation drawing on voices from Public Health England, Alcohol Concern, the Home Office, the Advertising Standards Association and alcohol member bodies including SIBA, CAMRA and SWA. This shows that industry self-regulatory initiatives can respond quickly to emerging issues and public opinion, compared to the cumbersome passing of legislation, which can take place slowly over many years.
10. The Portman Group has more than [130 Code signatories](#) including producers, retailers and membership bodies. The Group is funded by thirteen member companies: Asahi UK Ltd; Aston Manor Cider; Bacardi; Brown-Forman; Budweiser Brewing Group UK&I; Campari; Carlsberg UK; Diageo GB; Heineken UK; Mast-Jäegermeister UK; Pernod Ricard UK, SHS Drinks and Thatchers Cider.

Positive UK and European trends on alcohol-related harm underscore the need to focus on harmful alcohol use

11. We do not seek to minimise the harm that alcohol can cause to some individuals and recognise that excessive alcohol consumption is dangerous and its effects should not be downplayed. People drinking at hazardous levels need professional support to overcome what are often multi-faceted challenges. We therefore believe the most effective way to tackle alcohol harm post-COVID is to focus on the minority of drinkers who are persistently drinking at the highest and most harmful rates and promote and support targeted interventions which help tackle the root causes of alcohol misuse.
12. However, there has been over a decade of falls on many measures of alcohol-related harm in the UK which should be recognised and celebrated. For example, the most recent Government curated data shows:
 - a. The moderate majority of UK adults (78%) either do not drink alcohol or stick **below the UK Government's lower-risk** guidelines of 14 units per week¹.
 - b. There has been a 20% fall in the number of British adults binge drinking (defined as exceeding 8 (men)/6 (women) units on the heaviest day of drinking) between 2007 and 2017 (the most recent statistics available)².
 - c. A 41% fall between 2007 and 2017 in the proportion of British adults who drank alcohol on five or more days in the last week³.
 - d. In England, the proportion of 11-15 year olds who drink at least once a week fell by 73% between 2006 and 2014. Under the new methodology it has remained at 6% since 2016⁴. In Wales, the proportion of 11-15 year olds who drank weekly declined by 80% (2002-18)⁵.
 - e. In England and Wales, the number of alcohol-related violent crime incidents has declined by 47% since 2009/10.⁶ In Scotland, the estimated number of incidents has fallen by around half in the last decade⁷.
 - f. Over the past 15 years, drinking driving accidents have fallen by 52.5% and casualties have fallen by 54%. Over the last 15 years, the number of fatal drink driving accidents have fallen by 58% and deaths by 59%⁸.

¹ [NHS England](#), November 2019 / [Scottish Health Survey](#), September 2020/ [National Survey for Wales](#), September 2020 / [Health Survey Northern Ireland](#), November 2018

² [ONS: Adults drinking habits in Great Britain](#), May 2018

³ [ONS: Adults drinking habits in Great Britain](#), May 2018

⁴ [NHS Digital: Smoking, Drinking and drug Use among Young People in England, 2018](#), August 2019

⁵ [School Health Research Network: 2017/18 Health Behaviour in School-aged Children](#), May 2019

⁶ [ONS: Nature of crime: violence](#), September 2020

⁷ [Scottish Government: Scottish Crime and Justice Survey 2018/19](#), June 2020

⁸ [UK Department for Transport: Reported Drinking and Driving](#), August 2020

13. The progress seen in the UK fits into a wider pattern of an increase in responsible consumption across Europe, which includes a 26% fall in the prevalence of Heavy Episodic Drinking across the WHO European Region from 2005 to 2016.⁹ There have also been associated declines on many measures of harm across other European countries including on underage drinking¹⁰ and drink driving¹¹.
14. The above positive trends should not be minimised in the working document when discussing the progress made across the world in tackling harmful alcohol use.
15. We are concerned that the working document at present is inconsistent in its use of terminology, resulting in a confusing blurring between a desire to reduce harmful use and reducing overall consumption, regardless of whether a person is already drinking within recommended Government guidelines.
16. As the moderate majority of drinkers in the UK and across Europe drink within Government recommended guidelines, we believe that the action plan should retain a singular focus on reducing harmful alcohol use and associated measures of harm, rather than diluting its focus with consumption of alcohol per se. This will allow the Global Strategy to retain its effective focus on harm reduction and its Member State mandate to focus on harmful use.
17. Furthermore, a zero-alcohol approach is likely to backfire as lecturing in places such as the UK and elsewhere in Europe conflicts with and misunderstands the cultural place of alcohol in society, as an important part of how we socialise and celebrate. Instead, the action plan should retain a primary focus on tackling harmful alcohol use whilst promoting moderate use within Government guidelines, as it represents a proportionate and sensible approach to risk.

Voluntary industry initiatives continue to play a valuable role in tackling harm

18. The alcohol industry stands apart from other sectors with its longstanding serious commitment, backed up credible action, to ensuring that its products are marketed and sold responsibly. This demonstrates that the action plan should see the alcohol industry as a valuable and positive partner in tackling the harmful use of alcohol.
19. Over its 30-year history, the **alcohol industry's responsibility actions through the Portman Group** has been shown to be a world-leading example of voluntary industry action to better inform and protect consumers, whilst tackling inappropriate marketing and promotions.
20. The Portman Group Code of Practice is a prime example of how voluntary action, with wide industry buy-in across the supply chain from producers to retailers, can have a demonstrable impact in protecting the most vulnerable in society. The Code is able to adapt faster to change than the cumbersome legislative process and, as the costs are borne by the industry, at no additional burden to the taxpayer. The Code also has a two-fold impact on the market. First the direct impact on products judged by the Independent Complaints Panel to have breached the Code, which are either altered or removed from the market. Secondly, the larger impact in continually driving up social responsibility standards across the industry as producers seek to remain the right side of the Code, in contrast to statutory legislation which is often focused solely on minimum standards.

⁹ [WHO Global Status Report on Alcohol and Health](#), 2018

¹⁰ [IARD Trends Report on Underage Drinking](#), August 2019

¹¹ [IARD Trends Report on Drink Driving](#), October 2019

21. A further example of this commitment to agenda-setting responsibility, the Portman Group launched its 'Commitments to Action' (CAA) agreement back in 2003 which included a number of 'industry firsts' including ensuring that all member companies placed unit labelling on their drinks and ensured the placement of responsible drinking messaging on packaging and advertising¹².
22. The Portman Group's campaign work led to the founding of the Drinkaware Trust, now Drinkaware, the independent alcohol advice charity for UK consumers. In 2019 it reached more than nine million people through their website and social media, and 1.2 million people used their online tools to better understand the impact of alcohol on their lives.
23. The Portman Group has been instrumental in discussions with the UK Government to improve the sector, leading to the Public Health Responsibility Deal in 2012 which removed 1.9 billion units of alcohol from the shelves - primarily through lowering the average strength of products and improving consumer choice of lower alcohol products¹³.
24. The industry continues to voluntarily provide consumers with health-related information above and beyond that which is required by Government regulation. The vast majority of **the UK market adheres to the Portman Group's best practice guidelines**, which, amongst other recommendations, includes carrying a pregnancy warning, with around 95% of products in the UK carry such as warning¹⁴.
25. Our members, who produce over 50% of the drinks in the UK, have committed to voluntarily place the latest UK Chief Medical Officer guidelines on their packaging. The vast proportion of the industry are also voluntarily placing calorie and nutrition information on-pack and online as part of Europe-wide agreements¹⁵.
26. This commitment to alcohol responsibility is evident in initiatives across the whole of the sector, from the high retailing standards to prevent underage sales operated by the UK Retail of Alcohol Standards Group, to the industry-funded partnership schemes at a local level between local authorities and hospitality operators which ensure a safe, vibrant and prosperous night time economy in town centres across the UK.
27. Successful industry self-regulation in the UK can also be seen in wide industry compliance with UK Advertising Standards Authority (ASA) rules. The latest data from the ASA shows **that children's exposure to alcohol advertising on TV has more than halved in the past decade**, making up just 0.8% of the number of all TV ads seen by children each week¹⁶.
28. Industry initiatives are also able to take action on new frontiers such as digital marketing, which has proven difficult for policymakers due to the inherent cross-border nature of the technology. Digital marketing is a key area of focus for producers at an international level, with the International Alliance for Responsible Drinking (IARD) working in partnership with the largest digital platforms such as Instagram, Facebook and YouTube to raise standards. This includes the introduction of rigorous online safeguards to prevent minors

¹² [Portman Group: 30 Years of Responsibility](#), December 2019

¹³ [DHSC: Units of alcohol sold](#), April 2014

[Portman Group: Encourages industry to include 14 unit CMO guidance on labels](#), July 2019

¹⁴ [Hull University, The problem of drinking in pregnancy – and what to do about it?](#) January 2019

¹⁵ [Brewers of Europe Memorandum of Understanding with European Commission](#) / [SpiritsEurope Memorandum of Understanding with European Commission](#)

¹⁶ [ASA: Children's exposure to TV ads for gambling and alcohol: a 2019 update](#), May 2020

from seeing or interacting with alcohol brands online, as well as opt-outs for all consumers on platforms¹⁷.

29. However, while we as an industry are proud of our track record, we have always recognised the need for continual improvement. We are by no means defending the status quo. We are calling for the action plan to recognise that the industry is willing and able to play a leading and constructive role with Government and other parties in developing an improved collaborative approach as part of a whole-of-society approach to strengthen regulation.
30. We also believe that the above underscores that the action plan should recognise the broad suite of policy options available to tackle harm, especially the utility of industry voluntary initiatives, rather than prioritising a narrower set of restrictive policies under the SAFER initiative.
31. Lastly, the COVID-19 pandemic has demonstrated the importance of a whole-of-society approach and how the alcohol industry can play a vital role in protecting health and supporting local communities. Portman Group member producers have worked collaboratively with local authorities in the UK and across the world to produce millions of litres of hand sanitiser and donate personal protective equipment to hospitals, care homes and community facilities¹⁸.

Portman Group
December 2020

¹⁷ [IARD: Online marketing](#), November 2019 / [IARD: Actions to accelerate reductions in underage drinking](#), January 2020

¹⁸ [Portman Group blog](#), May 2020 – see also our [COVID-19 blog series](#) for further information of industry responsibility during COVID-19

Portuguese Brewers Association

Country/Location: Portugal

URL: www.apcv.pt

Submission

Based in Lisbon, Portugal, the Portuguese Brewers Association brings together more than 99% of national brewers' and provides a voice to support the interests of Portuguese breweries. The Portuguese Brewers Association promotes the positive role played by beer and the brewing sector in Portugal and advocates the creation of the right conditions to allow brewers to continue to freely, cost-effectively, and responsibly brew and market beer.

Attachment(s): 1

00177_15_public-consultation-who-apcv-statement.pdf

WHO working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

- The Portuguese Brewers Association comments and suggestions for consideration

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:

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. In Portugal, since 1991 until nowadays there is a pronounced decline of beer consumption per capita. 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.
- All these declines have 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.

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 Portuguese Brewers Association has for example committed, in the absence of a legal obligation set in national or EU law, to voluntarily roll out ingredients and calorie labelling across the continent.
- The brewing sector is voluntarily doing so in 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 “*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*”.

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 Portugal, 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 (34% decrease in Portuguese beer market) have not been matched at all by equivalent increases in beer sales from the retail sector.

- The Portuguese beer market is forecast to have declined between 15-20% in 2020, meaning a major drop in the consumption of lower alcohol beverages, due entirely to the closure of the hospitality sector.
- 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.

Lisbon, November 4th, 2020

Francisco Gírio
Secretary General
Portuguese Brewers Association

The Portuguese Brewers Association

Based in Lisbon, Portugal, The Portuguese Brewers Association brings together more than 99% of national brewers' and provides a voice to support the interests of Portuguese breweries. The Portuguese Brewers Association promotes the positive role played by beer and the brewing sector in Portugal and advocates the creation of the right conditions to allow brewers to continue to freely, cost-effectively, and responsibly brew and market beer.

Prevention Network/Michigan Coalition to Reduce Underage Drinking and Michigan Alcohol Policy Promoting Health and Safety

Country/Location: United States of America

URL: www.mcrud.org

Submission

Just some brief comments about the action plan to strengthen the implementation of the Global strategy to reduce the harmful use of alcohol.

Attachment(s): 1

00498_22_12.13.2020-response-to-who.pdf



December 13, 2020

Response from the Michigan Coalition to Reduce Underage Drinking (MCRUD) and Michigan Alcohol Policy Promoting Health and Safety (MAP) to the World Health Organization regarding the action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

On behalf of the State of Michigan (United States of America), MCRUD and MAP, appreciate the World Health Organization for developing the action plan and are pleased to submit comments about this document below.

- Any fact sheets, reports, professional development opportunities, or other resources that the World Health Organization can create to help Member States to implement the plan would be helpful and encouraged.
- We would like data to be as “local” as possible on the problems related to alcohol use.
- To the extent possible, we would like the WHO to do their best to help organizations get adequate funding to implement strategies to reduce the harmful use of alcohol.
- Since the alcohol industry does not have the same end goals as Member States or the WHO Secretariat, we believe that actions for the alcohol industry be separated out from the main document into a separate section within the plan.
- We encourage the World Health Organization to engage in regular communication with the alcohol industry about actions they can take to reduce their marketing to youth as well as other possible effective strategies to reduce alcohol related harm.
- We would like the WHO to closely monitor the social media marketing of alcohol to youth.

Michigan Coalition to Reduce Underage Drinking
3815 W. St. Joseph Street, Ste. C-100, Lansing, MI 48917
Phone: 517.393.6890
E-mail: mcrud@preventionnetwork.org
www.mcrud.org

The mission of the Michigan Coalition to Reduce Underage Drinking is to provide leadership on state and national issues and to assist individuals, grassroots groups, and organizations to reduce underage drinking locally.

Michigan Alcohol Policy Promoting Health & Safety
P.O. Box 232, Perry, Michigan 48872
Phone: 517.803.5586
E-mail: michiganalcoholpolicy@gmail.com
www.michiganalcoholpolicy.org

Advocating for laws and policies that reduce the illegal and harmful use of alcohol.

Project Extra Mile

Country/Location: United States of America

URL: <https://www.projectextramile.org/>

Submission

PEM's response and recommendations to the World Health Organization's (WHO) 'Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol' are based upon the following focus areas:

- Addressing advertising, price, and the availability of alcohol;
- Expanding health services;
- Preventing alcohol industry involvement in public health initiatives;
- Coordinating efforts; and
- Monitoring progress.

Attachment(s): 1

00420_59_pem-who-comments-final.pdf



Project Extra Mile (PEM) is a non-profit organization whose mission is to *advocate for evidence-based policies and practices to prevent and reduce alcohol-related harms*. PEM is a network of community partnerships working in the U.S. with an active coalition in the Omaha, Nebraska metropolitan area.

PEM's response and recommendations to the World Health Organization's (WHO) '**Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol**' are based upon the following focus areas:

- Addressing advertising, price, and the availability of alcohol;
- Expanding health services;
- Preventing alcohol industry involvement in public health initiatives;
- Coordinating efforts; and
- Monitoring progress.

Addressing Advertising, Price, and the Availability of Alcohol

Page 4: "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."

Page 5: "Satellite and digital marketing present a growing challenge for the effective control of alcohol marketing and advertising."

Suggestion: PEM supports calls for a Framework Convention on Alcohol Control.

Suggestion: Commercial advertising must be regulated by governments rather than allowing the alcohol industry to utilize self-regulated marketing codes. Print, radio, television, and online advertising, including digital ads on social media, reach youth and other vulnerable groups alike yet disproportionately target young people. Research has found that the marketing of alcoholic beverages is a causal factor for underage alcohol use.¹ The alcohol industry promotes self-regulation as an appropriate means of regulating alcohol marketing activities. Still, evidence suggests that the guidelines of these codes are violated routinely, resulting in excessive alcohol marketing exposure to youth as well as content that is potentially harmful to youth," according to Noel et al.²

Suggestion: PEM recommends the addition of strategies to address both the pricing and availability of alcohol. More than a decade after an initial global analysis, the findings of recent research found that pricing policies and restrictions to alcohol availability and marketing continue to represent a highly cost-effective use of resources, according to Chisholm et al.³

Expanding Health Services

Page 5: "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."

Suggestion: We support the utilization of evidence-based screening and brief interventions in health services. Coordinated efforts must also be prioritized to increase awareness of alcohol-related harms among the public. Awareness of alcohol as a causal risk factor for cancer remains low in the U.S.⁴ Increased awareness of this link is also associated with support for alcohol policies, according to research by Bates et al.⁵

Preventing Alcohol Industry Involvement in Public Health Initiatives

Page 4: "Strong international leadership is needed to counter interference of commercial interests in alcohol policy development and implementation to prioritize the public health agenda for alcohol in the face of a strong global industry and commercial interests."

Page 6: "The COVID-19 outbreak has underscored the importance of developing appropriate alcohol policy responses, alcohol-focused activities and interventions during public health emergencies."

Page 13: "Such awareness, along with the development and enforcement of alcohol policies, needs to be protected from interference by commercial interests."

Suggestion: We encourage WHO to maintain a strong policy against commercial/industry involvement in public health initiatives to address alcohol misuse, including a prohibition on industry involvement in policy development. Policy development and education/awareness campaigns must be based on sound scientific evidence. Research has indicated that industry-sponsored programs are ineffective and counterproductive in reducing excessive alcohol use and related harms.⁶

Coordinating Efforts

Page 13: "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."

Suggestion: The SAFER initiative is a valuable tool in developing high-impact, cost-effective policies.

Page 15: "Increased coordination between health and other sectors such as finance, transport, communication, and law enforcement are required for implementation of effective multisectoral measures to reduce the harmful use of alcohol."

Suggestion: Improved coordination among public health and other sectors is vital. However, in doing so, the alcohol industry should not be involved in developing public health initiatives aimed at preventing alcohol misuse. The alcohol industry has consistently derailed and reducing public health initiatives' effectiveness aimed at preventing excessive alcohol use and related harms. For example, drunk driving is a significant contributor to global road traffic fatalities, yet few countries have laws that meet international best practices, according to Hoe et. Al. The study's authors noted the impact of the alcohol industry's opposition to meaningful policies, which are perceived as a direct threat to alcohol sales.⁷

Monitoring Progress

Page 12: "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."

Suggestion: We recommend that this action step be made with additional specificity. Setting a schedule will increase the likelihood of achieving goals and help to ensure that effective strategies are being implemented as intended.

Page 12: "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."

Page 13: "Regularly produce national reports on alcohol consumption and alcohol-related harm targeting decision-makers and the public with information on alcohol's contribution to specific health and social problems and dissemination of information through available modern communication technologies."

Suggestion: We recommend that progress be tracked and reported according to a specific timeline, such as every other year. More frequent reporting will also allow participating entities to identify their need for technical assistance and additional resources as challenges are identified.

¹ Sargent, JD & Babor, TF. The relationship between exposure to alcohol marketing and underage drinking Is causal. *J Stud Alcohol Drugs Suppl.* 2020 Mar; Sup 19(Suppl 19):113-124. doi: 10.15288/jsads.2020.s19.113. PMID: 32079567; PMCID: PMC7063998.

² Noel J, Lazzarini Z, Robaina K, & Vendrame A. Alcohol industry self-regulation: who is it really protecting? *Addiction.* 2017 Jan;112 Suppl 1:57-63. doi: 10.1111/add.13433. Epub 2016 Oct 27. PMID: 27188660.

³ Chisholm, D, Moro, D, Bertram, M, Pretorius, C, Gmel, G, Shield, K & Rehm, J. (2018). Are the "best buys" for alcohol control still valid? An update on the comparative cost-effectiveness of alcohol control strategies at the global level. *Journal of Studies on Alcohol and Drugs.* 79. 514-522. 10.15288/jsad.2018.79.514.

⁴ Scheideler, JK & Klein, W. Awareness of the link between alcohol consumption and cancer across the world: A review. *Cancer Epidemiol Biomarkers Prev.* April 1 2018 (27) (4) 429-437; DOI: 10.1158/1055-9965.EPI-17-0645.

⁵ Bates S, Holmes J, Gavens L, et al. Awareness of alcohol as a risk factor for cancer is associated with public support for alcohol policies. *BMC Public Health.* 2018;18(1):688. Published 2018 Jun 4. doi:10.1186/s12889-018-5581-8.

⁶ Babor, TF, Robaina, K, Brown, K, Noel, J, Cremona, M, Pantani, D, Peltzer, R & Pinsky, I. Is the alcohol industry doing well by 'doing good'? Findings from a content analysis of the alcohol industry's actions to reduce harmful drinking. *BMJ Open*, 2018; 8 (10): e024325 DOI: 10.1136/bmjopen-2018-024325.

⁷ Hoe, C, Taber, N, Champagne, S, & Bachani, A. Drink, but don't drive? The alcohol industry's involvement in global road safety, *Health Policy, and Planning*, czaa097, <https://doi.org/10.1093/heapol/czaa097>.

Prometheus - Das Freiheitsinstitut

Country/Location: Germany

URL: <https://prometheusinstitut.de/>

Submission

With great concern did we read the WHO's "action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol". While we wholeheartedly support on the goal to reduce the harmful use of alcohol, we are not convinced that the proposed means achieve this goal. In some cases, these means are even likely to achieve the opposite by penalizing responsible drinkers instead of helping those who suffer health consequences from a harmful use of alcohol. We identify five fallacies of the Action Plan, namely: (1) alcohol consumption equals harmful alcohol consumption, (2) higher prices deter harmful consumption, (3) Bootleggers and Baptists, (4) Smart Regulation must be Public Regulation, (5) A Ban on Advertisement means a Ban on Harmful Consumption.

Attachment(s): 1

00205_25_who-consultation-prometheus.pdf

Summary:

With great concern did we read the WHO's "action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol". While we wholeheartedly support on the goal to reduce the *harmful* use of alcohol, we are not convinced that the proposed means achieve this goal. In some cases, these means are even likely to achieve the opposite by penalizing responsible drinkers instead of helping those who suffer health consequences from a harmful use of alcohol. We identify five fallacies of the Action Plan, namely: (1) alcohol consumption equals harmful alcohol consumption, (2) higher prices deter harmful consumption, (3) Bootleggers and Baptists, (4) Smart Regulation must be Public Regulation, (5) A Ban on Advertisement means a Ban on Harmful Consumption.

Fallacy Nr 1: Alcohol Consumption Equals *Harmful* Alcohol Consumption

The WHO aims to develop "an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol". What at first seems to be a reasonable attempt to combat the misuse of alcohol worldwide turns out to be a fundamental attack on consumer sovereignty. Because instead of caring and helping those who suffer serious health consequences from an unhealthy consumption of alcohol, the working paper seems to condemn the general consumption of alcohol instead.

This becomes clear when the working paper refers numerous times to the per capita consumption of alcohol as a measure for misuse of alcohol. There is however no empirical evidence that establishes a relationship between the reduction of per-capita alcohol consumption and the reduction of harmful consumption (Duffy and Snowden, 2014). Therefore, the WHO seems to have a problem with alcohol consumption per se: "*The accumulated evidence indicates that alcohol consumption [sic!] is associated with inherent health risks, although these risks vary significantly in magnitude and health consequences among drinkers.*" (WHO, 2020, p. 4). Furthermore, it is not even acknowledged that the consumption of moderate amounts of alcoholic beverages can even have health benefits (French and Zavala, 2007).

Hence, by putting the emphasis on *alcohol consumption* instead of *harmful alcohol consumption*, the WHO's tries to penalize the majority of responsible drinkers for the alcohol abuse of a small minority.

Fallacy Nr. 2: Higher Prices Deter Harmful Consumption

As argued before we agree with the WHO's more general point to "Reduce the Harmful Use of Alcohol." However, there is no empirical evidence for the strategy of the WHO's to achieve a safer use of alcohol by "rais[ing] prices on alcohol through excise taxes and other pricing policies" (WHO, 2020, p.11). As economic reasoning suggests such an approach is likely to penalize the modest and responsible consumption of citizens while leaving untouched the citizens who are affected by harmful use of alcohol and suffer from addiction. The economic theory of elasticity demonstrates how heavily the demand of a good decreases when prices are raised by for example excise taxes. Since consumers of alcohol of beverages are an heterogenous group, raising taxes will affect them differently.

While modest and responsible consumers do not regard alcohol as an integral component of their everyday life, the price elasticity is likely to be high for them: Higher prices will lead to a relatively strong decrease in responsible consumption. Citizens with harmful drinking habits and addictive tendencies are unlikely to be deterred by higher prices. They will rather cut back on other expenses and use the excess

money to consume alcohol for increased prices. Price elasticity of demand for harmful alcohol consumption is relatively inelastic: Higher prices will lead to a relatively small decrease in harmful consumption.

But since the WHO's and our goal is the reduction of harmful alcohol consumption and not of modest and responsible consumption, higher prices should not be the preferred mean.

Fallacy Nr 3: More Regulations leads to Less Commercial Influence

While it is worthy of critique that the proposed higher taxation will not help the very citizens that need our assistance, the situation is made even worse when we consider that an increased regulatory burden on alcohol consumptions profits the well-intentioned regulators and the ill-intentioned commercial interest of illicit alcohol dealers (Yandle, 1983).

From the prohibition of the 1920s, the current War on Drugs up to today's discussion about harmful alcohol consumption, well-intentioned regulators like the authors of the WHO action plan are convinced that a higher regulatory burden will benefit citizens affected by the harmful use of certain substances (Simmons, Yong, Thomas, 2011). These "Baptists" find unexpected support in the commercial interest of facilitators of illicit and illegal alcohol consumption: "Bootleggers" have an economic interest in higher prices for legal alcohol and enforced bans and restrictions on alcohol because it will increase the profit margins in the illicit trade in alcohol (Thornton, 1991).

Both parties, Baptists and Bootleggers, gain while one party loses – the consumers. To avoid partnering up with the commercial interest of the illicit market the WHO should resist the temptation to artificially raise prices and push for harder restrictions on alcohol. Instead it should focus on approaches that actually help the harmed and support the responsible.

Fallacy Nr 4: Private Interest Groups do not care about public health.

The WHO portrays the alcohol industry as driven by cold-hearted profit maximisers whose interest run diametral to public health interests. In the words of the WHO: *"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."* (WHO 2020, p. 4). Therefore, the WHO demands a strict "Command-and-Control" regulatory approach then fends off private interest against public health.

This depiction however ignores the last 30 years of empirical research conducted in the field of regulation that shows how cooperation between regulators and regulatees can lead to fruitful outcomes. For example, as shown by Cogliese and Lazar (2003), a Management-based, cooperative regulatory approach can work if there is sufficient overlap between the firm's interest and the net social benefit. This ensures fewer costs, higher compliance, and higher flexibility for the firms.

As alcohol brands too care about their long-term reputation, they also have an incentive to work out a regulatory solution that helps those with an unhealthy use of alcohol. Therefore, both parties can work out a regulatory solution that achieves the goal of increased public health with the least burdensome

means for private firms. It is a myth that regulation in the public interest can only be delivered by public officials.

Fallacy Nr. 5: A Ban on Advertisement equals a Ban on Harmful Consumption

The right to advertise one's product is a fundamental right of firms to exert their commercial freedom. Therefore, a complete ban on advertising and marketing altogether, as proposed by the working paper of the WHO, is a severe curtailment of this right and must demonstrate a strong empirical and moral background. While there is mixed empirical evidence for the hypothesis that advertisement for alcoholic beverages motivates non-drinkers to start drinking, there is no evidence that advertising for alcoholic beverages increases the consumption of drinkers (Smith and Foxcroft, 2009; Nelson 2010). Therefore, there exists no relationship between harmful consumption of alcohol and advertisement for alcohol. Thus, instead of depriving an entire industry of their right to commercial freedom, a focus on education and prevention of harmful use of alcohol is the least burdensome legal instrument and should be chosen instead.

As we have shown, the WHO's latest working paper on the harmful use of alcohol has serious flaws in its scope, methodology and reasoning. Let us hope that the next draft of this paper puts increased emphasis on providing help for the victims of alcohol and not tries to patronize responsible consumers.

Literature:

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Duffy, J. and Snowdon, C. (2014): Punishing the Majority: The flawed theory behind alcohol control policies. *Current Controversies* No. 49 London: Institute of Economic Affairs.

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Simmons, R.; Yonk, R.; Thomas, D. (2011): Bootleggers, Baptists, and Political Entrepreneurs – Key Players in the Rational Game and Morality of Regulatory Politics. *The Independent Review* 15(3): 367-381.

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Thornton, M. (1991): Alcohol Prohibition Was a Failure. *Cato Policy Analysis* 157.

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.

Yandle, B. (1983): Bootleggers and Baptists: the education of a regulatory economist". *Regulation* 7 (3): 12-16

Public Health Agency of Catalonia / Department of Health / Government of Catalonia

Department/Unit: *Program on Substance Abuse*

Country/Location: Spain

URL: <https://drogues.gencat.cat/ca/inici/>

Submission

The Program on Substance Abuse, Public Health Agency of Catalonia (<https://drogues.gencat.cat/ca/inici/>) is pleased to support WHO's efforts in keeping alcohol policy on the global agenda. To keep advancing the work done so far, especially in the last 10 years since the adoption of the Global Strategy to Reduce the Harmful Use of Alcohol and the regional Action Plans, action at the highest possible level is needed.

As such, Catalunya applauds the WHO proposal for a Global Action Plan and the opening of public consultation so that all those who work to reduce the problems caused by alcohol and to improve policies for prevention and treatment can participate in its development.

Attachment(s): 1

00316_72_letter.pdf



Participation in the 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

The Program on Substance Abuse, Public Health Agency of Catalonia (<https://drogues.gencat.cat/ca/inici/>) is pleased to support WHO's efforts in keeping alcohol policy on the global agenda. To keep advancing the work done so far, especially in the last 10 years since the adoption of the Global Strategy to Reduce the Harmful Use of Alcohol and the regional Action Plans, action at the highest possible level is needed.

As such, Catalunya applauds the WHO proposal for a Global Action Plan and the opening of public consultation so that all those who work to reduce the problems caused by alcohol and to improve policies for prevention and treatment can participate in its development.

We believe that this plan covers the necessary features for establishing a framework for collaboration between all the different actors. The focus on synthesis stands out, with its structure across six action areas, the detailing of different actors' roles at Secretariat, Member State and non-State level, and for the operationalisation of objectives, indicators and a defined timeframe.

Now is the moment to make considerable advances in affordability and labelling policy. Sub-national level governments do not have the legal jurisdiction to achieve this alone. Only strong international action will see advances in this area. Harmful products should not be affordable and should have warning labels; this requires regulation.

The effectiveness of communication efforts can be enhanced by a 'world day' recognising initiatives to reduce alcohol related harm which take place around the 15 November, such as the European *Awareness Week on Alcohol related Harm* (<https://www.awarh.eu/>), and the Catalan "*Setmana de Sensibilització sobre els riscos de l'alcohol*" (https://drogues.gencat.cat/ca/ciutadania/menys_es_millor/) among others, and by aligning efforts to coordinate focus on areas of most interest each year.

While understanding the focus on 'best buys' in the SAFER initiative, we consider recognising the need for work focusing on reducing the harm to others to be key; with particular regard to alcohol use in pregnancy and its impact on families (especially children), and also the impact of alcohol use on the workplace and the community.

Regarding the role of the economic operators, and acknowledging the importance of their inclusion in the discussion, we call on WHO to enforce strict standards in relation to this group and to prevent them from interfering with policy implementation.



The document could benefit from having a section describing the particularities of each region in relation to the plan. At the European level in particular, we urge the EC to adopt a European action plan on alcohol for the EU, and to reactivate mechanisms for coordinating activity between member states. Without this tool, implementation at the EU level will be significantly weakened.

Similarly, it is important to continue to promote networks between international and non-state actors. The proposed forum is a good tool, above all if there is a long term plan and that specific milestones and objective are established, as well as coordination mechanisms to ensure continuity through the work. It is key, that the forum provides a space for the different actors to come together and coordinate efforts.

From the perspective of Catalunya, where we have promoted networking with the support of important initiatives such as INEBRIA (www.inebria.net) and the Alcohol Policy Network (APN) (www.alcoholpolicynetwork.eu), we consider aligning the actions of all actors with common objectives to be key.

Finally, we want to end by emphasising the importance of action at the sub-national and local level, and the recognition and visibility of this work. In Catalunya we have adopted the objectives of the European action plan to reduce the harmful use of alcohol 2012-2020 and we continue to work to align our actions with international guidelines keeping in mind our specific context and needs.

Joan Colom i Farran
Director of the Programme on Substance Abuse

Queensland Coalition for Action on Alcohol

Country/Location: Australia

URL: www.qcaa.org.au

Submission

QCAA believes there are three high priority issues needing to be addressed if alcohol related harms are to be moderated.

Firstly, there is a need for an informed population, a population that is aware of the risks associated with consuming various quantities of alcohol. This priority demands that:

- Advertising of alcohol products not be misleading;
- Warning labels be included on all alcohol products;
- Community education on harms be undertaken including in schools and workplaces.

Secondly, there is a need to facilitate the pricing of alcohol so that the cost of treating those adversely affected be factored into the price paid by the consumer. There is a particular need to limit the sale of low cost alcohol products so that those who consume the most alcohol are discouraged. Taxation policies and minimum unit pricing are two ways of achieving the above objective.

Thirdly, in many countries there are few treatment services for those whose consumption of alcohol is at the level of abuse or dependence. Typically, governments have been reluctant to either provide services, support existing services or evaluate the quality of services that are provided. There is a need to develop the infrastructure of service delivery and view this infrastructure as guided by what is known about best practice.

Attachment(s): 1

00294_60_who-global-alcohol-strategy-submission.pdf



Queensland Coalition for Action on Alcohol
GPO Box 590, Brisbane, Queensland, 4001, Australia
contactus@qcaa.org.au

11 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 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 and have the following comments and suggestions for your consideration.

The Queensland Coalition for Action on Alcohol (QCAA) is a coalition of non-government organisations with the aim to reduce alcohol harms and improve the health and wellbeing of people living in the state jurisdiction of Queensland, Australia. The alliance is facilitated by the Drug Awareness and Relief Foundation (Australia). QCAA is a broad-based Alliance that has come together to pool collective expertise and knowledge around the strategies that are needed to reduce the harms associated with the consumption of alcohol.

Some of the member of QCAA include the Australasian College of Emergency Medicine, Australian Medical Association of Queensland, Cancer Council Queensland, Drug and Alcohol Nurses Australia, Drug ARM, Foundation for Alcohol Research and Education, Lives Lived Well, Royal Australasian College of Surgeons, Salvation Army, Queensland Alcohol and Drug Research and Education Centre, Queensland Homicide Victims Support Group and the Queensland Network of Alcohol and other Drug Agencies.

The QCAA advocates for policies within the power of the government of the state jurisdiction of Queensland to address the harms of alcohol. The most recent policy platform of QCAA developed in conjunction with our membership highlighted the following key areas of focus:

1. **Promoting Healthier Communities** though providing comprehensive, evidence-based health information to consumers focusing on the link between moderate alcohol consumption and chronic disease especially focusing on the seven types of cancer, mental health and heart disease.
2. **Managing availability, price and promotion of alcohol** through the introduction of controls such as volumetric taxation and minimum unit pricing. Minimum unit pricing that has shown to have reduced harms from alcohol in the Northern Territory of Australia. Restrictions on alcohol advertising around schools, playgrounds and on Government owned infrastructure is another strategy to manage availability and promotion.
3. **Improving community safety and amenity** by retaining Queensland's successful legislation restricting the late-night availability of alcohol through a reduction in trading hours, and extending these availability restrictions to cease the sale of all takeaway liquor between 10pm and 10am. The QCAA is also concerned about the growing online market for takeaway alcohol sales and delivery, and the associated risk of irresponsible service of alcohol to at-risk cohorts such as those under the age of 18 and heavily intoxicated people.

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

Strengthening the Action Plan

QCAA believes there are three high priority issues needing to be addressed if alcohol related harms are to be moderated.

Firstly, there is a need for an informed population, a population that is aware of the risks associated with consuming various quantities of alcohol. This priority demands that:

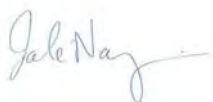
- Advertising of alcohol products not be misleading;
- Warning labels be included on all alcohol products;
- Community education on harms be undertaken including in schools and workplaces.

Secondly, there is a need to facilitate the pricing of alcohol so that the cost of treating those adversely affected be factored into the price paid by the consumer. There is a particular need to limit the sale of low cost alcohol products so that those who consume the most alcohol are discouraged. Taxation policies and minimum unit pricing are two ways of achieving the above objective.

Thirdly, in many countries there are few treatment services for those whose consumption of alcohol is at the level of abuse or dependence. Typically, governments have been reluctant to either provide services, support existing services or evaluate the quality of services that are provided. There is a need to develop the infrastructure of service delivery and view this infrastructure as guided by what is known about best practice.

Thank you for your consideration.

Yours sincerely,



Emeritus Professor Jake Najman
Chair
Queensland Coalition for Action on Alcohol



Dr Dennis Young AM
Secretary
Queensland Coalition for Action on Alcohol

Recover Alaska

Country/Location: United States of America

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

Submission

We appreciate the entire effort, and especially a focus on equity. Recommend considering incorporating people with lived experience into all stages of the work; recommend highlighting and including LGBTQ+ population as at-risk for alcohol use disorders; recommend expansion of family planning screening for people being treated or assessed for alcohol use disorders; recommend expansion of co-morbidities to include anxiety, traumatic brain injuries, and other mental illnesses; recommend excluding the alcohol industry from influencing research or policy solutions. Please see attachment.

Attachment(s): 1

00164_12_who-global-strategy-comments-recover-alaska.pdf



2 December, 2020

Response to WHO action plan on Global Strategy to Reduce Harmful Use of Alcohol

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:

Challenges and opportunities

- 6 (e) [page 7] – Thank you for including “Focusing on equity. Population-wide rates of drinking of alcoholic beverages are markedly lower in poorer societies than in wealthier ones. However, for a given amount of consumption, poorer populations may experience disproportionately higher levels of alcohol-attributable harm.”
 - We agree that there is a need to develop and implement effective strategies around equity. However, particularly in the United States, there is a lack of available research and data. Many surveys and polls focus on housed populations, and miss people experiencing houselessness. Another demographic often missing from polling data is a person’s gender identity and sexual orientation. While we know the LGBTQ+ population is disproportionately impacted, there are far less data getting about the specifics of harms, risks, and protective factors.

Guiding principles

- [page 9] – We really appreciate the guiding principles! Thank you especially for including (g). We also wonder about opportunities to include people with lived experience. Not only is statistical analysis and data critical to changing policy, programs, and behaviors, but including people who will be most impacted and/or who have the most relevant first-hand experience with the issues will prove enlightening and helpful toward crafting effective policy and programs, as well as will help with the groundswell of support that will be needed to enact any policy and social norm change.

Policy options and interventions

Area 2

- 21 (b) [page 12] – We are glad to see mention of the proliferation of screenings and brief interventions, especially among pregnant women and women of child-bearing age. It feels important to consider adding education for men to this list, as data show some of the women who drink alcohol while pregnant do so due to pressure from their partners. Additionally, including a family planning screening for women and men who are being seen/treated for alcohol use disorders, to ensure we are addressing the issue of potential FASDs from all sides.
- 21 (d) [page 12] – We appreciate the inclusion of co-morbidities, and would want the list to include additional mental health issues, such as anxiety, as well as traumatic brain injuries as part of the list. Alternately, include “and other related mental health issues” at the end of the list.



Area 5

- 28 (c) [page 15] – We wonder about the lack of decisiveness in the recommendation of “adopting policies to prevent sales to intoxicated persons and those below the legal age and *considering* the introduction of mechanisms for placing liability on sellers and servers in accordance with national legislations.” We recommend making this a firm proposal rather than merely a suggestion by changing the language from “considering” to “... and introducing mechanisms for placing liability...”

Area 6

- 29 [page 15] – We appreciate calling out young people and adolescents with regard to marketing concerns. Consider adding LGBTQ+ as an at-risk population, especially considering the vast majority of LGBTQ+ Pride events are sponsored by the alcohol industry and knowing LGBTQ+ is a population at higher risk for alcohol use disorders. This population should be specifically named, and cultural considerations should be recommended as part of this action item.

Overall

The other piece we recommend including is firm clarity that economic operators, the alcohol industry, should not be engaged in this process nor be allowed to influence research, policy, or practices. Thank you for this important body of work and your efforts to increase collaboration across sectors and across countries. We sincerely appreciate these efforts and the consideration of widespread feedback.

Regional Beverage Alcohol Alliance

Country/Location: Trinidad and Tobago

Submission

WHO Web-based Consultation on the Draft Action Plan to Implement the Global Strategy to reduce the harmful use of alcohol – RBAA Response.

1. Recognize the full menu of policy options included in the Global Strategy

The World Health Organisation (WHO) Member States have continued to emphasise a 'Whole of Society' approach, which calls for involvement of all stakeholders, including the private sector, to implement joint actions in support of the recommended areas in the Global Alcohol Strategy (GAS), such as drink-driving, education, and underage drinking.

- The Non-State Actors focus on 'SAFER' in the context that a 'one size fits all' approach is not practical for the Beverage Alcohol Sector (BAS), and that the prescriptions which may have worked for other interventions, were not recommendations that can work for beverage alcohol products, having regard to the high-valued nature of beverage alcohol products and their relevance to regional agriculture trade.
- CARICOM Member States (MS) which are predominantly small island states may find it onerous or impossible to protect their borders from illicit trade with the introduction of 'SAFER'.
- The BAS supports a balanced framework of co-regulation that sets appropriate boundaries for responsible advertising and promotion using the full range of policy options as contained in the GAS.
- The BAS commits to aggressively promote the strengthening of Responsible Codes of Conduct for Advertising and Marketing where they exist, and the adoption of these Codes where they are absent. These Codes of Conduct will be extended to cover the area of digital marketing and in particular, on-line sales.
- The BAS has already begun undertaking initiatives to achieve the implementation of the GAS that fosters greater engagement with the hospitality sector (hotels, restaurants, cinemas and bars) to promote responsible server training around age verification, recognising heavy episodic drinking, and supporting transportation alternatives during occasions and periods where the risk of the harmful use of alcohol exists. Designated driving campaigns as were implemented in collaboration between the Barbados Road Safety Association and Banks Holdings Limited - the Designate One public education campaign is a notable best practice. The campaign includes highway signage and a digital media component. The Stichting Verantwoord Alcoholgebruik Suriname (STIVASUR) – in 2017 launched its first Drink Drive campaign "Get Home Safely. Don't Drink and Drive" and in 2019 the "Who's the BOSS" Campaign was executed.
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in Trinidad and Tobago. The 'drink drive' campaign, which was shared with other CARICOM Member States, also benefitted from 'roll out' in many of these same States. Over the duration of the 'drink-drive' campaign in Trinidad and Tobago, the number of road traffic fatalities exhibited year on year declines- by 11%, in 2016 relative to the previous year (2015)14% .

2. Focus on reducing harmful use of alcohol

The BAS in CARICOM is committed to addressing the 'Harmful Use of Alcohol' through joined up action via the 'whole of society' approach articulated in the Political Declaration of the Third High Levelled Meeting on Non-Communicable Diseases (NCDs). At the regional level the BAS, has participated in the process aimed at developing a CARICOM Regional Approach to Addressing Non-Communicable Diseases, with a specific focus on the Harmful Use of Alcohol. The Harmful Use of Alcohol Working Group also reported through a Joint Meeting of the Council for Trade and Economic Development (COTED) and Council for Human and Social Development (COHSOD), in November 2019. Throughout the process, the Sector's 'economic operators' have been valuable contributors offering invaluable contribution in a number of key areas. The BAS has also provided the Joint Council of the COTED and COHSOD with a 'Strategy and Action Plan to address the Threat Posed to Caribbean People by The Harmful Use of Alcohol'.

- BAS has also responded to the harmful use of alcohol, through the presentation of substantive proposals to policy makers. Among the proposals made by Industry has been a shift from self-regulation towards a strong co-regulatory approach to advertising and marketing; support for drink-driving measures; and protection of vulnerable groups (underage, pregnant women); improving consumer information (including information on labelling); training in responsible serving (the consumer retail interface).
- The 'Sober Zones' initiatives which have been rolled out in several countries, including Barbados, Grenada, and Trinidad and Tobago provides the opportunity for patrons to 'hydrate' and 'recover'.

3. Recognize the positive contribution of economic operators

The COVID-19 pandemic has resulted in the closure of many businesses especially those involved in the hospitality industry. Consequently, unemployment in the Beverage Alcohol Sector has escalated, putting at risk the livelihoods of many employees and families, particularly those in rural communities.

The CARICOM BAS has engaged in a range of actions aimed at attenuating the impact of the crisis. Within CARICOM, the BAS has been among the first to provide sanitizers, and other Personal Protective Equipment (PPE) to 'front-line' healthcare workers and key segments of the public service and civil society. The Sector provided approximately 200 scholarships to mixologists, bartenders, and other hospitality professionals to upgrade their skills , in order to elevate the general standard of service delivery.

- The Industry has leveraged its marketing and communication competence to public service messaging on COVID-19. In Barbados and Trinidad and Tobago, major beverage brands have carried out effective advertising messages on electronic and social media aimed at educating the society, thereby reducing the 'risk of spread'. The BAS has utilised webinars to promote responsible consumption and to provide Industry facts of historical and cultural significance .

- The 'Ask Listen Learn' (ALL) program which targets 'underage' consumption developed by the Foundation for Advancing Alcohol Responsibility (FAAR), has been introduced in several Caribbean Countries (Dominica, St. Lucia, Grenada, Haiti). FAAR aims to eliminate drink driving and underage drinking and promotes responsible decision-making regarding alcohol use.
- The 'Ask, Listen, Learn' programme has emerged as one of the flagship underage drinking initiatives implemented by the BAS within CARICOM. The ALL programme targets the provision of information on the harmful effects of alcohol in the 8-11, school population and is delivered by the Ministries of Education, using materials produced by FARR. There are plans to extend the ALL programme to other CARICOM States.
- The ALL programme has also benefitted from independent evaluation. In the instance of St. Lucia, a post- programme implementation assessment for the 2017 -2018 revealed that discussion in the classroom on the subject of underage consumption and its varied negative effects on the body and the brain increased by 41%; and the frequency of family discussions on the harmful use of alcohol increased by approximately 18%.
- For Grenada, the results of both the pre-and post-programme survey evaluations for the 2016/2017 school year concluded that discussions about underage drinking increased 23% in the classroom and family discussions increased by 71%. Post-implementation evaluation has confirmed that there was a 30% increase in the knowledge gained on the manner in which underage drinking impacts on the growth of minors.

4. Fully incorporate economic operators within a whole-of-society approach

Several policy options are included in the GAS Action Plan for the reduction of the harmful use of alcohol that embraces a 'whole of society' approach. .

- The continued attempt by sections of the NGO Community to exclude the BAS from the dialogue and consultations aimed at arriving at policies and interventions to address the challenges associated with the harmful use of alcohol at both national and regional levels, remains a major impediment to the wholistic implementation of the GAS.
- In 2015, the Dominican Republic had the highest estimated rate of fatalities from road accidents in the Americas with 29.3 fatalities per 100,000 people, according to WHO's Global Status Report on Road Safety 2015. The high incidence of road fatalities in many Caribbean Countries has led to the formation of different models of partnership between the BAS and the public sector. In Trinidad and Tobago, the collaboration among the Ministry of Transport, with trusted NGO partners such as 'Arrive Alive' and the BAS has resulted in measurable declines. The BAS has also been an ardent supporter of the introduction of Blood Alcohol Content (BAC) Legislation and the breathalyser. Industry support in Countries such as Barbados, Grenada and Trinidad and Tobago are noteworthy .

5. COVID-19

The COVID-19 pandemic has become not just a public health disaster with rising infections and deaths in the world and the Caribbean, but also an economic catastrophe, characterised by negative rates of economic growth, and rising unemployment and poverty levels. For the BAS in CARICOM the relationship between alcohol consumption linked to the COVID-19 has not been comprehensively

explored. In this regard, greater research and analysis should be conducted with rigorous interrogation of the findings before public declarations are made.

- The BAS made important contributions to the development of a 'Framework for Risk Assessment, Management and Communication in the Time of COVID-19' document to support the private sector step-down from 'lock-down' measures in the wake of COVID-19. This contribution to 'preserving health' while 'safe-guarding livelihoods', was an important contribution to facilitating a heightened level of social responsibility.

6. Labelling

- Noting the mandate of the Heads of Government to tackle NCDs in CARICOM, the BAS has taken the lead on voluntary introduction of pictorial warning labels to inform consumers about the risks associated with alcohol consumption by at risk groupings (drink drive, underage, and pregnant women)..
- In a public announcement Raphael Grisoni, the Managing Director for Mount Gay Distilleries and the Barbados Director for the West Indies Rum & Spirits Producers' Association (WIRSPA) noted, 'the new provisions will also provide responsible drinking messages and calorie per serving information to assist consumers in making the right choices about how they drink'. The Caribbean Breweries Association (CBA) also adopted the decision at its recent Meeting to introduce pictorial warning messages on its products. The BAS intends to have pictorial warning messages on the labels of all beverage alcohol products by 2023.

7. Taxation

The BAS in CARICOM fully support a balanced approach to taxation that is evidence-based, and which considers national, religious and cultural contexts.

- The archipelagic States of CARICOM confront the challenge of securing their borders from the illicit trade in beverage alcohol products. In addition, the continental States of Belize, Guyana, and Suriname, confront the same challenge of 'porous borders' with adjoining States. In these contexts, many of the States in CARICOM offer textbook cases of the 'Laffer Curve' effect, whereby as taxes are raised beyond a certain level, it results in the decline in overall tax revenue collections. Examples of such phenomenon can easily be related to the Member States of Grenada and Jamaica, among others.
- Having regard to the forementioned environment among the CARICOM States, in which the BAS operates, the adoption of 'SAFER' may carry unintended consequences in the form of increases to illicit or unregulated alcohol production, counterfeit and informal trading, with the attendant negative consequences for revenues. Though not widespread among CARICOM Member States, there have been incidents of illicit and unregulated alcohol being associated with negative health outcomes and even morbidity.

8. International Trade

CARICOM Member States continue to be extremely vulnerable to exogenous shocks, including those transmitted from Developed Country trading partners, concentration and lack of diversification of the 'trade sectors and industries' as well as shocks induced from natural disasters, etc.

- Exports of beverages and alcohol is approximately 23% of total agri-product exports. Dismantling of the alcohol industry will result in alarming disruption to supply chains, with severe negative employment and poverty effects.
- Matters relating to international trade of alcohol products which have cultural significance to CARICOM should remain exclusively within the competence of the international trade institutions, (regional Institutions, WTO etc). It is inconceivable that concessions delicately balanced, and committed to in economic terms, could somehow be made to reflect other imperatives that were not present at the time when such concessions were initially offered.

9. Industry Funding of Alcohol Data Collection and Research

The BAS is committed to all opportunities for greater dialogue among stakeholders aimed at exploring modalities to enable private sector support for improved data collection as well as alcohol health and policy-related research.

- In this regard, the BAS maintains an avid interest in ensuring that evidence-based approaches to decision making, which are transparent, are followed. It is, however, important that data analysis covers the cultural and economic drivers, and peculiarities of the jurisdiction. For CARICOM Countries which are among the most tourism dependant in the World, the analysis must carefully reflect the differences between consumption of the 'Tourism Adjusted' population in reporting the results on per capita consumption.
- Attempts to report trends in alcohol consumption should recognise the pitfalls of double counting which can skew results in more instances than not, against the BAS in small States such as those of CARICOM.
- The BAS is therefore committed to providing support to staff training and to the modalities and collection of relevant data to drive evidence-based reporting and decision making.

Attachment(s): 1

00333_12_who-web-based-consultation-on-the-implementation-of-the-global-alcohol-strategy-final.pdf

WHO Web-based Consultation on the Draft Action Plan to Implement the Global Strategy to reduce the harmful use of alcohol – RBAA Response.

1. Recognize the full menu of policy options included in the Global Strategy

The World Health Organisation (WHO) Member States have continued to emphasise a ‘Whole of Society’ approach, which calls for involvement of all stakeholders, including the private sector, to implement joint actions in support of the recommended areas in the Global Alcohol Strategy (GAS), such as drink-driving, education, and underage drinking.

- The Non-State Actors focus on ‘SAFER’ in the context that a ‘one size fits all’ approach is not practical for the Beverage Alcohol Sector (BAS), and that the prescriptions which may have worked for other interventions, were not recommendations that can work for beverage alcohol products, having regard to the high-valued nature of beverage alcohol products and their relevance to regional agriculture trade.
- CARICOM Member States (MS) which are predominantly small island states may find it onerous or impossible to protect their borders from illicit trade with the introduction of ‘SAFER’.
- The BAS supports a balanced framework of co-regulation that sets appropriate boundaries for responsible advertising and promotion using the full range of policy options as contained in the GAS.
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Designate One public education campaign¹ is a notable best practice. The campaign includes highway signage and a digital media component. The **Stichting Verantwoord Alcoholgebruik Suriname** (STIVASUR)² – in 2017 launched its first Drink Drive campaign “Get Home Safely. Don’t Drink and Drive” and in 2019 the “Who’s the BOSS” Campaign was executed.

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¹ <http://www.thebhlgroup.com/page.cfm?p=pressreleases&read=BHL-road-safety>

² <https://www.facebook.com/STIVASUR/>

³ The TTBAAs does not claim exclusive responsibility for this downward trend in statistics. However, acting in partnership with the Trinidad and Tobago Police Service, the Ministry of Transport, and Arrive Alive, the decline bears some relationship to the success of this collaboration.

⁴ The Beverage Alcohol Sector, participates in CARICOM’s ‘Harmful Use of Alcohol Working Group’

- BAS has also responded to the harmful use of alcohol, through the presentation of substantive proposals to policy makers. Among the proposals made by Industry has been a shift from self-regulation towards a strong co-regulatory approach to advertising and marketing; support for drink-driving measures; and protection of vulnerable groups (underage, pregnant women); improving consumer information (including information on labelling); training in responsible serving (the consumer retail interface).
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⁵ <https://www.nowgrenada.com/2017/08/netherlands-insurance-extends-sober-up-zones-for-carnival-2017/>

⁶ [OECS DISTILLERIES SUPPLY MUCH NEEDED ALCOHOL TO FIGHT COVID-19 – CARICOM Today](#)

⁷ <https://www.wirspa.com/wirspa-wset-partnership/>

⁸ <https://zavvy.co/>

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⁹ [Grenada to roll out the Breathalyzer | Loop News \(loopslu.com\)](#)

¹⁰ [Police 'ready to enforce' Breathalyzer - Barbados Today](#)

¹¹ <https://www.thenewtodaygrenada.com/press-releases/producers-add-valuable-information-to-caribbean-rum-labels/>

Caribbean Breweries Association (CBA) also adopted the decision at its recent Meeting to introduce pictorial warning messages on its products. The BAS intends to have pictorial warning messages on the labels of all beverage alcohol products by 2023.

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- The BAS is therefore committed to providing support to staff training and to the modalities and collection of relevant data to drive evidence-based reporting and decision making.

RIVLAS - Representantes e Importadores de Vinos y Licores Asociado

Country/Location: Dominican Republic

Submission

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 del alcohol y tenemos los siguientes comentarios y sugerencias para su consideración:

RIVLAS, la asociación de Representantes e Importadores de Vinos y Licores Asociados es una asociación comercial que representa a los Importadores y Distribuidores de cerveza, vino y licores en la República Dominicana. RIVLAS mantiene su opinión de que la Estrategia Global sobre Alcohol 2010 ha proporcionado una base formidable para el desarrollo y la implementación de actividades, así como los medios necesarios para una colaboración más estrecha con el gobierno para abordar el abuso del alcohol en la República Dominicana. También creemos que el Plan de Acción debe mantener la intención original del documento de Estrategia Global sobre Alcohol.

RIVLAS también aboga fuertemente por una acción y respuesta de toda la sociedad defendida por la Declaración Política de Alto Nivel de las Naciones Unidas de septiembre de 2018; y el Objetivo de Desarrollo Sostenible # 17 de la ONU, que pide el estímulo y la promoción de asociaciones eficaces entre los sectores público y privado y la sociedad civil y la participación del sector privado. Este enfoque de toda la sociedad para abordar el problema del uso indebido del alcohol en el que nuestra colaboración a través del diálogo abierto en todas las categorías del sector y con numerosas partes interesadas que comparten información y mejores prácticas fortalecerá los resultados resultantes de la suma de nuestros esfuerzos. Además, creemos que estos esfuerzos se canalizan mejor a través del menú de opciones de políticas como se describe en la Estrategia mundial sobre el alcohol que permite la implementación de acciones apropiadas dado el contexto local y otras consideraciones relacionadas.

Estamos comprometidos a trabajar con todas las partes interesadas, incluidas las ONG y el gobierno, para abordar el uso nocivo de bebidas alcohólicas, entendiendo que estos esfuerzos, reforzados a largo plazo, traerán mejores resultados.

Memorando de Entendimiento ("MOU") suscrito entre el Ministerio de Salud y la Industria.

Prueba de ello es la importancia que le damos a nuestra responsabilidad en dar vida a las áreas acordadas en el memorando de entendimiento suscrito con el Ministerio de Salud en mayo de 2016 que se centró en las siguientes áreas:

1. Abordar el consumo de alcohol por menores de edad, en particular las ventas a los menores de la edad legal para beber / comprar.
2. Conducir bajo los efectos del alcohol.
3. Fortalecimiento de los códigos de publicidad y marketing.
4. Etiquetado.
5. Involucrar al comercio como socios en iniciativas de consumo responsable.

6. Diálogo continuo sobre la política de comercialización de bebidas alcohólicas.

El MOU fue firmado por el Ministro de Salud Pública y Asistencia Social, RIVLAS, asociación de Representantes & Importadores de Vinos y Licores Asociados, ADOPRON La Asociación Dominicana de Productores de Ron y ADOFACE La Asociación Dominicana de Fabricantes de Cerveza y continúa en vigencia a medida que avanzamos los esfuerzos que implementamos juntos para abordar los daños causados por el uso nocivo del alcohol.

Colaboración con el Gobierno en la introducción de los alcoholímetros (2017-2019)

En el 2015, la República Dominicana tuvo la tasa estimada más alta de muertes por accidentes de tráfico en las Américas con 29,3 muertes por cada 100.000 personas, según el Informe sobre la situación mundial de la seguridad vial 2015 de la OMS. Esta preocupante estadística reunió una asociación exitosa entre el Gobierno y la Industria que dio como resultado el lanzamiento exitoso del programa de alcoholímetros República Dominicana.

En este mismo año, la Alianza Internacional para el Consumo Responsable (IARD) inició un proyecto de 3 años para ayudar a abordar el problema como parte de los Compromisos Globales de la Industria (<http://www.producerscommitments.org>). Tras las reuniones preliminares entre el gobierno y la IARD, con los representantes de la industria nacional y la asistencia regional de Cervecería Nacional Dominicana (Ab-InBev), Diageo y Pernod Ricard habilitaron a la IARD y la industria nacional y regional de bebidas alcohólicas estableció un programa para ayudar a prevenir la conducción bajo los efectos del alcohol.

La Alianza Internacional para el Consumo Responsable o IARD por sus siglas en inglés y UNITAR, el Instituto de las Naciones Unidas para la Capacitación e Investigación, brindaron apoyo y capacitación a los Oficiales de Policía y la División de Transporte del Gobierno, abordando la conducción bajo los efectos del alcohol como parte del MOU.

Es el compromiso de las Industrias con la Estrategia Global sobre Alcohol lo que nos ha permitido también apoyar al Gobierno junto con la Alianza Internacional IARD para el Consumo Responsable en el lanzamiento del Alcoholímetro en agosto de 2019.

Como parte de nuestro compromiso como industria, en el año 2017 y 2018, la IARD y los socios de la industria donaron ocho (8) sistemas de prueba de aliento que comprenden cuarenta (40) dispositivos a INTRANT, para ser utilizados en puntos de control de sobriedad de alta visibilidad junto con la capacitación proporcionada por expertos internacionales. La IARD trabajó con INTRANT para desarrollar materiales educativos y de campaña con información sobre los nuevos límites de BAC y los efectos del alcohol en los conductores, junto con recomendaciones y consejos para desalentar la conducción en estado de ebriedad.

En preparación para el lanzamiento, INTRANT en alianza con Industria, liderada por un convenio con UNITAR el Instituto de las Naciones Unidas para la Capacitación e Investigación, reunió a las Autoridades Policiales de la República Dominicana, la Policía de Mérida y la Secretaría de Seguridad Pública del Estado de Yucatán, durante varios días de intercambio de mejores prácticas y desarrollo de capacidades. La Secretaría de Seguridad Pública, que comenzó a utilizar las prácticas de aplicación de alta visibilidad de HVE hace unos 20 años, tiene un largo historial de éxito y el fuerte apoyo de la población de la ciudad de Mérida. Participantes especialmente elegidos de INTRANT y DIGESETT, quienes son la Administración

General de Seguridad del Tránsito y Transporte Terrestre de la República Dominicana, participaron en tres días de presentaciones, discusiones y talleres liderados por expertos en Seguridad Vial. Los asistentes también observaron el Centro de Control de la Jefatura de Policía y un punto de control de sobriedad real. El alcoholímetro finalmente se lanzó en agosto de 2019 en la ciudad capital de Santo Domingo.

Colaboración con el Ministerio de Educación en la lucha contra el consumo de alcohol por menores.

Además, los miembros de RIVLAS (Diageo y Pernod Ricard) copatrocinaron y colaboraron con el Ministerio de Educación de la República Dominicana, para abordar el problema del consumo de alcohol en menores a través de un programa piloto del programa “Ask Listen Learn” desarrollado por la Foundation for Advancing Alcohol Responsibility (FAAR), que es una organización que lidera la lucha por eliminar la conducción en estado de ebriedad, el consumo de alcohol por menores y promueve la toma de decisiones responsable con respecto al consumo de bebidas alcohólicas en los Estados Unidos (www.responsibility.org).

El Programa existe desde hace dos décadas y se ha introducido ampliamente en más de 20,000 escuelas en los Estados Unidos, Canadá y más recientemente en el Caribe en las islas de Granada, Dominica, Santa Lucía y la República Dominicana.

En la región del Caribe, “Ask, Listen and Learn” está siendo implementado por FAAR, quienes capacitan a Maestros en los Ministerios de Educación y cuentan con el apoyo de fondos de Importadores y Productores regionales de bebidas alcohólicas.

El programa “Ask, Listen and Learn” les enseña a los niños sobre los peligros del consumo de alcohol por menores de edad. En términos más generales, “Ask, Listen and Learn” presenta varios ejercicios interactivos diseñados para desarrollar habilidades para la vida, incluido el pensamiento crítico, el desarrollo del carácter, la resolución de problemas, la toma de decisiones y la autogestión saludable.

En República Dominicana, el Programa Piloto fue lanzado en colaboración con MINERD, el Ministerio de Educación de República Dominicana en 10 escuelas impactando a casi 2,000 estudiantes. El programa continuará en el 2021 tanto en línea como en clase, siempre que las condiciones lo permitan en relación con la pandemia de COVID 19.

Fortalecimiento de los Códigos de Autorregulación.

Adicionalmente, RIVLAS también se ha unido a otros miembros de la industria y asociaciones locales con su propio código de autorregulación de marketing y publicidad que se revisará continuamente dado el cambiante panorama empresarial, incluido el creciente advenimiento del comercio electrónico y el marketing digital, esto a través de las mejores prácticas internacionales compartidas desde sus miembros.

RIVLAS está comprometida y apoya los esfuerzos para lograr resultados positivos y de mayor escala en el trabajo que se puede lograr a través de asociaciones público-privadas en el espíritu de un enfoque de toda la sociedad para abordar el abuso del alcohol. Creemos que podemos lograr más cuando trabajamos juntos.

Comentarios Generales.

Con respecto a las acciones descritas en el plan de acción general para fortalecer la implementación de la Estrategia Global para reducir el uso nocivo de alcohol, nos gustaría reforzar lo siguiente:

- Seguimos comprometidos con el apoyo al Gobierno en áreas en las que podamos colaborar a largo plazo para reducir el uso nocivo de alcohol.
- Continuamos apoyando el menú de opciones de políticas delineadas por la Estrategia Global sobre Alcohol como la mejor manera de trabajar juntos para implementar acciones apropiadas para abordar el daño del alcohol dado el contexto local en la República Dominicana. Creemos que los “best buys”, indicados bajo el marco de “SAFER”, no son las únicas políticas de menú disponibles para reducir los daños relacionados con el alcohol, y que las intervenciones dirigidas a la educación y la prevención suelen ser más eficaces.
- Apoyamos este enfoque por encima de cualquier otro enfoque que pueda tener consecuencias no deseadas, como la producción y distribución de alcohol informal o ilícito.
- 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.
- Continuaremos utilizando los recursos que tenemos a mano según la membresía de nuestra compañía individual para construir sobre el trabajo que hemos logrado hasta la fecha abordando las diferentes áreas acordadas con el Ministerio de Salud a través del MOU suscrito en el año 2016.
- Como se indicó anteriormente, esto incluye apoyo a INTRANT y DIGESETT en los esfuerzos de conducir y no tomar en la República Dominicana a través de la capacitación de Oficiales de Policía por parte de expertos acreditados internacionalmente en el uso e implementación de alcoholímetros, esto dado el cambio reciente en el Gobierno y el personal resultante.
- Tenemos la esperanza de seguir teniendo un diálogo abierto, fructífero y continuo con el gobierno en varios aspectos, es decir, salud, educación, policía, transporte, que han contribuido al éxito de los programas implementados hasta la fecha. También esperamos colaborar con otras instituciones interesadas, para beneficiarnos de un enfoque colaborativo de sociedad, que es tan importante a la hora de abordar el abuso del alcohol.

Attachment(s): 0

Ruffino srl

Country/Location: Italy

URL: www.ruffino.it

Submission

Dear sirs,

Wine has been in our Culture for thousands of year and part of our life and meals. In Italy and more broadly in Med see. The vast majority of people, ever since, have adopted balanced and moderate attitude with it. All those people have never seek for alcohol. They chose to drink and enjoy the wine. Not the alcohol inside. Those that seek the alcohol have no interest in the wine itself. They just seek the alcohol and its effect on their senses and body. So the issue cannot be the wine itself but the wrong behaviors. That's why the Education is the solution. Education heal people. Prohibitions would penalize moderate drinkers and would not save the alcohol seekers.

Behind the wine sector there are millions of farmers that are guardians and architect of the Environment. The Agro/Wine tourism brings people into areas that would have normally been abandoned but instead are valued, restored, guarded. We cannot forget this while we all talk about safeguard the environment.

Farm to Fork is an incredible opportunity for EUROPE where we can strengthen the link between the right farming practice with the right personal attitude to diet. So to food and wine. Let's figure out how to develop programs on education and information withing Farm to Fork strategy to help in making people aware of what they eat and drink to make the best possible choices. Informed and mature choices. On everything, including wine of course. Education and people's mature choices is the solution in our modest opinion.

Respectfully

Sandro Sartor

Attachment(s): 0

Russell Family Fetal Alcohol Disorders Association

Country/Location: Australia

URL: www.rffada.org

Submission

Yes

Attachment(s): 1

00245_43_letter-to-world-health-organisation.pdf

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organisation (WHO)
Avenue Appia 20 1211 Geneva
8 December 2020

Dear Director-General,

RE: 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)

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 and have the following comments and suggestions for your consideration.

The **Russell Family Fetal Alcohol Disorders Association** (rffada) is a national not-for-profit health promotion charity dedicated to prevention and ensuring that individuals living with FASD or at risk of fetal alcohol exposure have access to diagnostic services, post diagnostic multidisciplinary management planning and parent peer support.

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 the harmful use of alcohol and the ensuing social consequences.

rffada sees the impact that alcohol has on people including alcohol dependency and in particular we see Fetal Alcohol Spectrum Disorder [FASD] as supporting parents and caregivers of people with FASD and their children is our core business.

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. 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 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 and economic 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:

- 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.

Getting this Action Plan right is critical to the rffada and its aims and objectives. We are a volunteer organisation in operation for more than thirteen years without any operational funding whatsoever. We have more work than our volunteers can deal with and we are in the process of applying for funding to continue our critical work. Without the rffada, many children of parents unable to pay for the assessments and testing, would not have a diagnosis. One of our critical goals is to reduce the prevalence of FASD in Australia. This Action Plan will support this goal.

Thank you for your consideration.

Yours faithfully,

Elizabeth Anne Russell
Executive Officer
Russell Family Fetal Alcohol Disorders Association
+61412550540

SAAPA Botswana

Country/Location: Botswana

Submission

Botswana government should be encouraged not to reverse the policies that are in place under pressure from the alcohol industry; instead the decisions should be based on evidence based information regarding the comparison of the health and economic harm caused by alcohol versus the economic gains brought by alcohol.

Botswana government should be encouraged to adopt a conflict-of interest policy and refrain from the allowing the industry to prescribe the policy to suit their interests.

The Alcohol Levy Fund should be meaningfully used for its original purpose.

Attachment(s): 1

00440_73_submission-to-who-from-saapa-botswana-2020.pdf

SAAPA Botswana Submission

WHO online Consultation

Review of Global Alcohol Strategy

12 December 2020

Context

It is disheartening to watch Botswana regressing in its alcohol policies under pressure from the industry. Government has lowered the alcohol levy from 55 to 35 percent for both local products and imports and have extended trading hours. Through these actions, the government expects the industry to reciprocate the “*good gesture*” by stepping up their Corporate Social Responsibility (CSR) initiatives, which include sponsorships and / or the so perceived rehabilitation programmes for those suffering from substance abuse. In addition, government has intimated that they expect that there will be a consequential reduction in retail prices for the benefit of consumers, literally meaning increased affordability and accessibility. The majority of Botswana abstain from consuming alcohol. However, there is a slow shift in the social norm through marketing, availability and affordability. Consumption is steadily increasing, especially amongst young people with an estimate of 74.1% of male and 38% of female drinkers aged 15-19 years drinking heavily.

Sports and Advertising

Botswana successfully banned sports sponsorship under the past administration. The current administration is courting the industry to come back into sports sponsorship. The industry in return is requesting government to further reduce the levy if they are to agree to the proposal.

Imported, cross border television broadcasting from the SABC TV in South Africa into Botswana brings with it, heavy alcohol adverts, despite the policy of no alcohol advertising in Botswana. This advertising exposes young minds whilst watching their favourite sport channels. We foresee this trend leading to the reversal of the no alcohol advertising policy in Botswana. The Botswana government must be encouraged to adopt a conflict-of-interest policy to reduce the impact of industry interference to change policy to suit their profit and business interests.

Liquor Control Authority (LCA)

Currently, members of the liquor control authority do not get any orientation on the laws of the Act as custodians of it. Members of the LCA understand their key mandate to be to facilitate business for Botswana and therefore resort to dishing out of the licenses without information-based consideration.

The Botswana government and civil society organisations like SAAPA requires technical and financial support to train LCA members on the health harm caused by alcohol consumption to enable evidence-based alcohol licensing decisions. The LCA requires training to understand how outlet density contributes to harm like road crashes and interpersonal violence, especially GBV.

Give consideration to health issues:

Given the experience brought about by COVID 19, it is obvious that there are serious health issues brought about by alcohol consumption. These need to be taken into account and incorporated into the

Act as we move forward. For example, bottle sharing is a common practise. This practise is facilitated by container sizes for example beer is sold in 1l containers. The Botswana government should be encouraged to enact the law to dictate maximum sizes of containers.

There needs to be alcohol outlet density restrictions. Crowding of alcohol outlets should be discouraged given issues of distancing and possible ill behaviour of drunkards.

The Value Chain

The big international chain stores that operate across borders like Checkers, Spar and wholesalers are almost monopolizing the sale of alcohol through buying in bulk at reduced prices, sell to themselves (own retail shops / bottle stores) and are able to offer low prices. This disregard for the value chain operations makes alcohol affordable and easily accessible. The cross-border retail trade monopoly also impacts on the small business prospects for Batswana.

Alcohol Levy Fund

Botswana introduced a tax levy on alcohol through the Statutory Instrument 90 of 2008. The intention was to promote projects designed to combat alcohol abuse and minimize effects of alcohol abuse. To date, the levy continues to be used for supporting other general government activities that are not related to its original objectives. As a result, the intended outcomes remain unreached.

The Botswana government should be support to optimally use the provision of the Act, to ringfence a percentage of the revenue generated; and be encouraged to establish an independent health promotion foundation like in Thailand that could more effectively carry out the mandate intended through the Act.

Submitted by:

Prisca Mokgadi

Chairperson, SAAPA Botswana

SAAPA Namibia

Country/Location: Namibia

URL: <http://saapa.net/countries/namibia>

Submission

Change existing legislation to increase the purchasing age from 18 years to 21 years, especially in the light of a significant percentage of young people over 18 years still attending school. Non-compliance of this provision by retailers should be heavily fined.

Attachment(s): 1

00383_39_saapa-namibia-submission-best.pdf

SAAPA Namibia submission
WHO online consultation

Review of Global Alcohol Strategy

Action Area 1

1. A clear statement on COI should be made.

Conflict of interest policy poses a threat for the development and adoption of evidence-based alcohol policies in Namibia, with reference to the WHO 'best buys – availability, pricing and marketing' and the more recent SAFER package. A significant risk of conflict of interest exist with the Namibian government's partly due to accepting a "donation" from the alcohol industry, and thus influencing policies and actions. Ohlthaver and List (O&L) – the owner of Namibia Breweries, reportedly "donates" beer annually to the government through the Minister of Foreign Affairs for distribution to their mission abroad. The national soccer team are sponsored by Windhoek lager, which indirectly promotes consumption. The Namibian Broadcasting Corporation receives advertising revenue. Of particular concern is that the chairman of NBC is also the chairman of Ohlthaver and List (O&L). There is also a close association of the governor of the Khomas region with the board of O&L. The Khomas region produces almost 97% of all alcohol in Namibia. How does the governor balance the "fiduciary responsibility to represent the best interests" of the O&L group with that of central government?

This conflict extends into the non-state actor sector. The current board of O & L includes an African Methodist Episcopal Church (Amec) reverend and Council of Churches in Namibia (CCN) member.

2. Member states should be supported to adopt a COI policy.

The examples listed above points to the need for WHO to promote and the Secretariat to support the Namibian government to adopt a conflict of interest policy. This would be in line with the existing NATIONAL ASSEMBLY, CODE OF CONDUCT & DISCLOSURE OF MEMBERS' INTERESTS, Adopted, 28 November 2002, Chapter 4, CONFLICT OF INTEREST, page 4,

https://publicofficialsfinancialdisclosure.worldbank.org/sites/fdl/files/assets/law-library-files/Namibia_MP%20Code%20of%20Conduct%20and%20Interest%20Disclosure%20Law_2002_en.pdf

3. WHO Secretariat discontinue dialogues with industry.

SAAPA Namibia also proposes that the existing dialogues between the WHO secretariat and the alcohol industry discontinues. These dialogues are non-binding and therefore have limited value for a public health agenda. Instead, it serves to ‘window dress’ and advance the alcohol industries’ commercial interests and offers them the platform as a legitimate ‘partner’.

Action Area 2

1. The Namibian government should be supported with resources and technical support to adopt The SAFER technical package.
2. The Namibian government should be encouraged to introduce an alcohol levy like Botswana and Thailand, which can have the two-fold effect of reducing consumption and generating revenue for government which could support health promotion interventions.
3. Member states should be encouraged change existing legislation to increase the purchasing age from 18 years to 21 years, especially in the light of a significant percentage of young people over 18 years still attending school. Non-compliance of this provision by retailers should be heavily fined.
4. The Namibian government should be supported to increase restrictions on marketing, including a ban on TV advertisements.
5. As a non-state actor, SAAPA Namibia should be supported financially and technically to undertake communication and advocacy campaigns to promote safer drinking norms and increased regulation.

In Namibia glass bottle containers are used in violent interactions. These glass bottles should be replaced with plastic or cans with screw caps to discourage ‘finishing the drink after opening’.

Teurai Rwafa **September 30, 2015** , <https://movendi.ngo/blog/2015/09/30/namibia-action-needed-on-alcohol/> said that 'Namibia: Action Needed On Alcohol, Alcohol Industry, Obstacle To Development, Policy'.

SAAPA Zimbabwe

Country/Location: Zimbabwe

Submission

Southern Africa Alcohol Policy Alliance in Zimbabwe (SAAPA Zimbabwe) is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS. SAAPA Zimbabwe is a national network of civil society organisations advocating for a public health centered, evidence-based alcohol policy to reduce alcohol harm in Zimbabwe

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.

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

Attachment(s): 1

00429_64_who-workingdoc-consultation.pdf



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

Southern Africa Alcohol Policy Alliance in Zimbabwe is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*. SAAPA Zimbabwe is a national network of civil society organisations advocating for a public health centred, evidence-based alcohol policy to reduce alcohol harm in Zimbabwe

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
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- 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.

SALBA, BASA and Vinpro

Country/Location: South Africa

URL: www.salba.co.za

Submission

Our Commitment to addressing the harmful use of alcohol

We seek to:

- Demonstrate what can be achieved when government, private & civil sectors work together to tackle the harmful consumption of alcohol;
- Demonstrate support to international efforts to improve health and social outcomes for individuals, families and communities in South Africa;
- Reduce underage drinking & alcohol related road fatalities;
- Strengthen and expand marketing codes of practice;
- Provide consumer information and responsible product innovation; and
- Work with retailers support to reduce harmful use of alcohol.

Attachment(s): 1

00513_31_industry-submission-who-working-document.pdf



Submission of comments in respect of the Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Submitted 13 December 2020

by

Beer Association of South Africa (BASA)
South African Liquor Brandowners Association (SALBA)
Vinpro

SOUTH AFRICAN INDUSTRY POSITION ON THE GLOBAL STRATEGY TO REDUCE HARMFUL USE OF ALCOHOL

INTRODUCTION

The South African Alcohol Industry is totally committed to responsible manufacturing, advertising and marketing practices and to encouraging adults who choose to consume alcohol to do so in a responsible manner and in moderation.

Given the global scope and representativeness of our Industry, we welcome the opportunity to participate in this consultation process, and we view this as an important opportunity to continue and advance the exchange of views between the World Health Organisation and economic operators. We are grateful for these dialogue opportunities over the past years and hope this process will result in mutually satisfactory commitments which will contribute to the reduction of the harmful use of alcohol.

We would like to draw attention to the following specific issues:

- ✓ We are of the view that the strategy should concentrate on the issues surrounding harmful use of alcohol and the need to change certain consumer behaviour. We are encouraged to note that the harmful use of alcohol is in decline across many countries. This is also the case for example in South Africa; while we fully acknowledge there remains more work to be done, the factors that allowed for this success should be appropriately evaluated and further strengthened, where possible.
- ✓ We have initiated and promoted programmes that reduce drinking and driving, underage drinking and heavy episodic drinking, among other responsibility initiatives. These programmes, both intended to change behaviours and perceptions, have been impactful and effective.
- ✓ While we acknowledge that our work on the harmful use of alcohol should continue, and that there are still too many alcohol-related deaths, it is important to recognise the cooperation of public, private and civil society stakeholders in our achievements.
- ✓ It is important that the strategy recognises the economic benefits of the manufacturing, distribution, marketing, advertising and sale of alcohol for both markets and governments. Across many countries, the Liquor industry makes a positive contribution to local economies, particularly in rural areas.
- ✓ The Industry believes the best public health measures are those that balance individual choice with the well-being of society as a whole, through targeted initiatives and policies that aim at reducing the harmful use of alcohol. In practice, this means on-going strong public sector, civil society and private sector collaboration to tackle harm and strengthened by evidence based research.
- ✓ We also believe that all stakeholders involved should consider reasonable options to tackle harm as outlined in the working document, as well as other proven interventions, rather than a limited focus on a limited number of policy measures and interventions. This will ensure that alcohol-related harm can be most effectively addressed given specific local context, culture and environments.

- ✓ The industry will continue to invest in responsible drinking initiatives and activities aimed at tackling alcohol-related harm that have a measured impact on the behaviours and perceptions of our consumers. In that regard, we would encourage improvement of data collection and sharing among all parties, especially in low- and middle-income countries, which are critical to inform and design impactful actions.

1. South African Industry Social Compact

Over the last 4 months, the industry has collectively developed a social compact to address the harmful use of alcohol in South Africa. Through an integrated effort, we have developed a harmful use reduction strategy derived from data analysis and benchmarking. The Industry has produced a new coordinated strategy with the ambition to effect behavioural change in South Africa to reduce the harmful use of alcohol and promote a culture of responsible drinking. The three focus areas from data analysis and benchmarking are: Drinking & Driving, Binge Drinking and Underage Drinking.

For each focus area, we have prioritized flagship programmes which have the potential of sustainably impacting the Harmful use of Alcohol in SA. Success of this new coordinated strategy will require support and commitments from government, enabling regulatory considerations as well as effective enforcement.

The Social Compact aims to effect behavioural change in South Africa to reduce the harmful use of alcohol and promote a culture of responsible drinking, which in the long-term will be more effective than increasing regulations. In addition to the programmes and interventions being rolled-out under the social compact, we are committed to self-regulation in respect of advertising and promoting responsible consumption.

The Social Compact addresses many of the issues raised by the South African Government

- Underage Drinking;
- Aware Advertising guidelines;
- Responsible Trading Hours through self-regulation; and
- Industry commitment to continue transformation in the sector.

Our Commitment to addressing the harmful use of alcohol

We seek to:

- Demonstrate what can be achieved when government, private & civil sectors work together to tackle the harmful consumption of alcohol;
- Demonstrate support to international efforts to improve health and social outcomes for individuals, families and communities in South Africa;
- Reduce underage drinking & alcohol related road fatalities;
- Strengthen and expand marketing codes of practice;
- Provide consumer information and responsible product innovation; and

- Work with retailers support to reduce harmful use of alcohol.

Our priority areas for future actions to reduce the harmful use of alcohol and strengthen implementation of the global strategy to reduce the harmful use of alcohol are as follows:



The industry is establishing an advisory panel that will consult on the harmful consumption strategy and implementation thereof. An Industry Board & Advisory Panel on Harmful Use Reduction is crucial to the success of the Social Compact.

The Advisory panel will comprise by members of the communities & Health, Value Chain Associations, Business Sector & Government.

Mandate of the board will ensure that:

- ✓ **Industry's initiatives enjoy the broad support** of government, the liquor trade industry, the health industry and the broader business community;
- ✓ Industry's initiatives and commitments are based on evidence and opinions provided by credible independent experts;
- ✓ Industry is made aware of key changes and developments that may impact the alcohol industry; and
- ✓ Industry is able to access key decision-makers from government, the liquor trade industry, and the health industry and the broader business community.

The main purpose of setting up an Industry advisory panel is to bring credibility to our activities, subject matter expert inputs and insights as well as access to key decision makers as and when needed. To meet our needs we have identified 4 groups of stakeholders which should take part in the advisory panel



2. Other measures to implement the global strategy to reduce the harmful use of alcohol:

2.1 Health warning labels

We support warning messages on beverage alcohol products that cautions against drink-driving, underage consumption and drinking during pregnancy.

2.2 Introduce a balanced framework of co-regulation

We will support a balanced framework of co-regulation that sets appropriate boundaries for responsible advertising and promotion. Industry will aggressively promote the strengthening of Responsible Codes of Conduct for Commercial Communication. These codes reflect best practice in the advocacy for responsible drinking, does not bear any linkage between alcohol and health, attainment of status, sporting success, skill, or portray social and sexual success. Other initiative to foster the implementation of the strategy can be:

- ✓ Advocate abstinence as a valid individual choice and does not present alcohol as a rite of passage to adulthood;
- ✓ Work to restrict marketing to underage and vulnerable groups;
- ✓ Ensure that event sponsorship and promotions contracts embed adherence to and full acceptance of the provision of the Commercial and Communication Code of Conduct; that events are responsibly marketed and include responsible drinking messages in their marketing and at the event;

- ✓ Require event organisers to implement age verification and adhere to the sensible drinking guidelines set out in our codes;
- ✓ Foster greater engagement with bars and restaurants to promote server training around age verification, recognising and addressing inebriation and providing support for transportation alternatives.

2.3 Public Education and Public Awareness

We actively encourage responsible drinking in all our commercial communication. In order to achieve this, greater commitment should be exhibited to working more closely with our Ministries of Health, Education and other relevant line Ministries in developing and supporting a variety of sensitization materials, communication tools and responsible drinking messages.

2.4 Barriers to increased dialogue

Dialogue and consultations on future policies and intervention modalities to treat with the challenges of the harmful use of alcohol remains a major impediment. We remain committed to a fully engaged stakeholder in shaping and implementing the public policy agenda at the Global, National, Provincial and Regional levels.

2.5 Public-private partnerships

The public – private partnership approach holds incredible promise in support of reversing the harmful use of alcohol. Where laws / regulations are inadequate, the PPP mechanism can be a useful tool to developed broad-base support and consensus for legislative improvements. An example is non-alcoholic beverages that were introduced to the market by different industries.

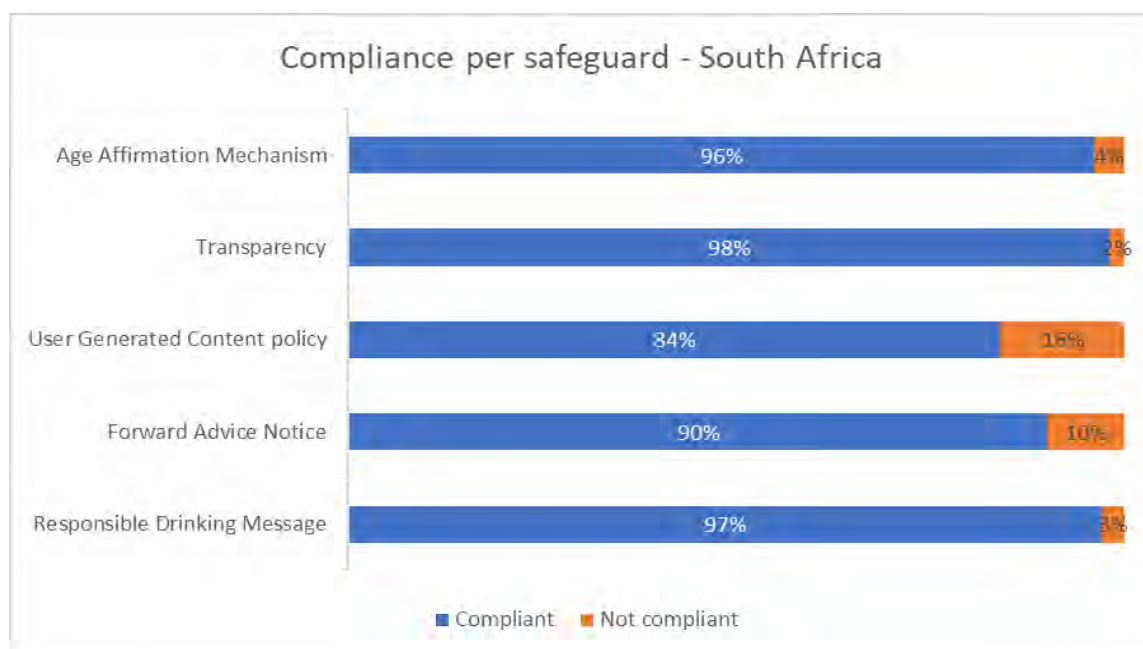
2.6 Enforcement, monitoring and evaluation of interventions and regulations

Instituting a results based management system to better attain a reduction in the harmful use of alcohol is one approach that can be pursued. It can be useful to explore the incorporation of performance targets of the various stakeholders.

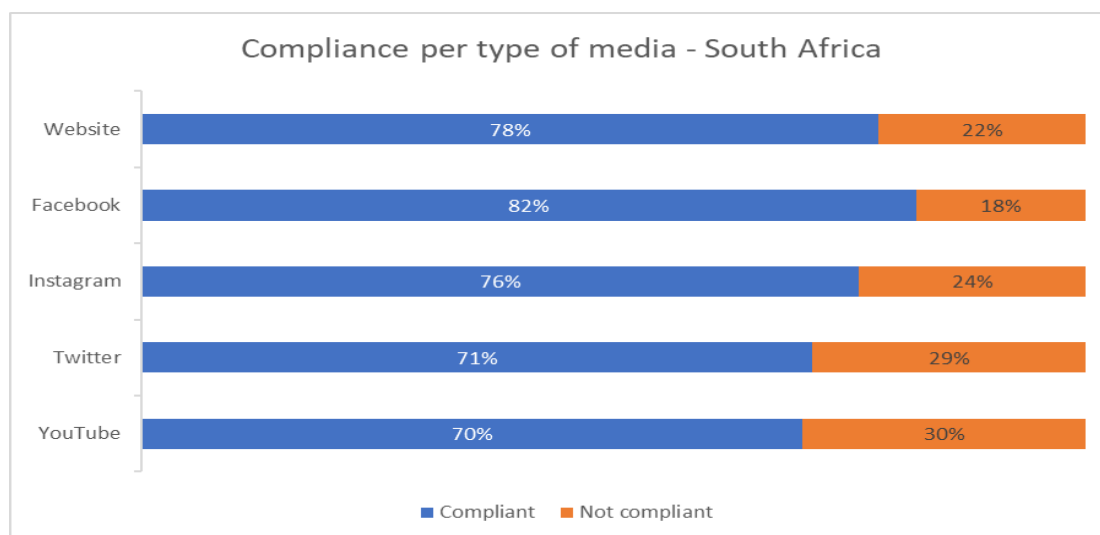
From 2018 to 2019, EASA and its network of expert reviewers from self-regulatory organisations conducted a yearly monitoring project to verify compliance with two industry marketing commitments: The International Alliance for Responsible Drinking (IARD)'s Digital Guiding Principles (DGPs) and the World Federation of Advertisers' Responsible Marketing Pact (RMP).

The monitoring exercise assessed whether alcohol brand websites and social media profiles had safeguards in place to help ensure minors' online experience is free from alcohol ads. Fourteen countries, including South Africa, were monitored. Expert reviewers assessed whether the following five digital safeguards were present on alcohol brand websites and social media profiles: an age affirmation mechanism transparency notice, user generated content policy, forward advice notice and responsible drinking message.

Nearly all profiles were found to be compliant with the Transparency safeguard (98%), with the Responsible Drinking Message safeguard (97%) and the Age Affirmation Mechanism (96%). 9 out of 10 websites and social media profiles monitored were judged by the South African self-regulatory organisation as being compliant with the Forward Advice Notice safeguard. 84% of the profiles were compliant with the User Generated Content Policy.



More than 4 out of 5 Facebook profiles were just as compliant with all safeguards (82%). The compliance rate was slightly lower for websites (78%), Instagram profiles (76%), Twitter profiles (71%) and YouTube profiles (70%).



3. STAKEHOLDER ENGAGEMENTS AND CHALLENGES

3.1 Public Policy responses to address the harmful use of alcohol.

The Industry has been a major supporter of public policy to address the harmful use of alcohol that is entrenched by government as a whole and the society including tackling unregulated manufacturing.

3.2 Public Policy Engagement

The Industry continues to proactively work with public policy decision makers in finding proactive approaches and solutions. Despite the increased political distance between industry and Government, we are always keen to deliberate and participate in the public policy space in support of the NCDs agenda and the reduction in the harmful use of alcohol, and Industry remains ready to collaborate.

3.3 Threat of Excessive Tax Increases

One significant area of priority focus should be in reducing the size of the illicit alcohol market. Illicit trade is undermining legitimate economic activity, depriving governments of revenues for investment and exposing consumers to health risks.

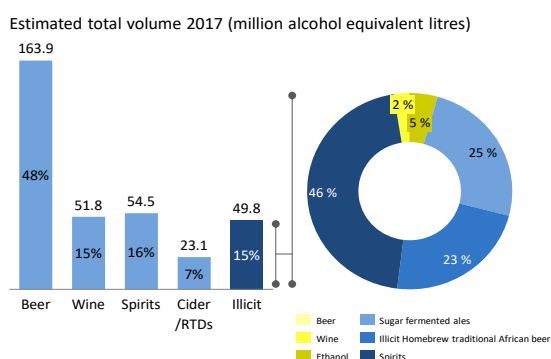
Excise duties in South Africa have increased consistently above inflation since 2002. On average excise represents almost 25% of most beers, 40% for every spirituous product purchased and 11% for wine.

Excessive excise taxes may have unintended consequences and inadvertently push people toward higher risk options, including informally or illicitly produced alcohol, and encourage cross-border purchasing and/or smuggling¹³. According to the World Health Organization (WHO), unrecorded alcohol consumption and smuggling are higher where alcohol taxes are higher.

Illicit alcohol is a growing problem in South Africa where counterfeit and smuggling together present almost 70% of total illicit volumes. Illicit alcohol, including smuggling and at-home-production, are primarily a problem for beverage categories with stronger alcohol content¹⁵. As is evident from the graph below, almost 50% of the illicit alcohol market in South Africa consists of spirits at an average strength of 43% alcohol by volume (ABV).

Illicit alcohol is a significant market, accounting for an estimated 15% of alcohol sales by volume and resulting in a fiscal loss of R6.4 billion

Illicit alcohol accounts for ~15% of the total market in SA by volume of alcohol equivalent—similar to licit wine or spirits

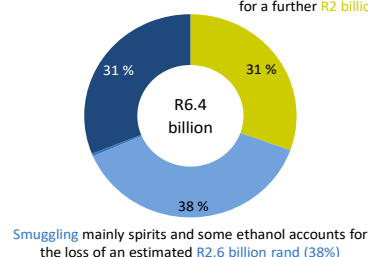


Resulting in a fiscal loss of approximately R6.4 billion in 2017, over 10% of total indirect taxes paid by industry¹

Fiscal loss is primarily through three sources

Counterfeit and illicit production, mostly of spirits (and some wine) results in a R2 billion (31%) loss

Tax leakage from under-reporting and mis-classification of sugar fermented ales as wine accounts for a further R2 billion (31%) loss



1. Compared to the total 2019 indirect industry tax contribution of R61.2 billion as per FTI consulting report
Source: Euromonitor – Market Analysis for Illicit Alcohol in sub-saharan Africa (2018); FTI Consulting – The macro-economic impact of the liquor industry, 1 September 2020

High taxes can lead lower-income consumers to switch to illicitly produced alcohol or highly dangerous substitutes¹⁴. In the current economic situation where consumers are under increasing pressure as disposable incomes decline, the demand for more affordable alcohol is growing. If safe and affordable legal options aren't made available, the risk is that consumers will resort to illicit alternatives, many of which could be dangerous to

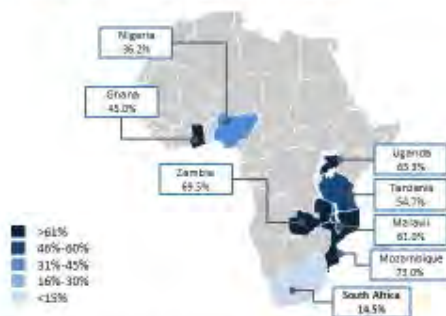
their health. In addition, consumption of illicit substitutes robs legal manufacturers of their income and in turn, the fiscus from tax revenue. Knock-on effects are the decline of VAT and corporate income tax as profits are eroded.

The availability and accessibility of illicit substitutes in South Africa is a reality considering porous borders and poor enforcement within the context of high levels of illicit trading on the continent.

Compared to other African countries South Africa has a low percentage of illicit alcohol, but this is increasing due to the price gap in licit to illicit alcohol

In a comparison with eight other African countries, SA has by far the lowest percentage of illicit alcohol by volume (2017)

Share of illicit alcohol out of total alcohol volume (LAE)



1. WHO reported average of 11% unrecorded alcohol consumption within high income countries in 2016

Note: Data for alcohol volume sales use latest-year sizes for Ghana (2017), Malawi (2015), Mozambique (2017), Nigeria (2017), South Africa (2017), Tanzania (2017), Uganda (2017), and Zambia (2017)

Source: EuroMonitor – Market Analysis for Illicit Alcohol in sub-Saharan Africa (2018); WHO Global Status Report on Alcohol and Health (2018)

However, increases in excise have increased the price gap, incentivizing illicit trade

From 2012 to 2017, excise duties have increased at rates well above inflation, most significantly they have increased over 5 years by 57% for spirits and 195% for sugar-fermented beverages

These large increases in excise have lead to increased prices in licit alcohol, and an increased price gap between licit and illicit of 51% on average

This high disparity between prices has driven an increase in illicit trade, mostly in smuggling and counterfeiting of high value spirits

Over the same period, this has caused the illicit market to increase by 23% of total volume from 40,4 million LAE to 49,8 million LAE in five years to a total of 15% of the market by volume

This relative volume of illicit alcohol is small compared to African countries, but much larger than many developed nations¹

We fully support appropriate taxation of alcohol as part of an enabling regulatory environment to improve health and sustainable development. We support a transparent and a balanced approach to taxation that is evidence-based relevant to local policy.

The industry believes that whilst there is indeed a need for a balanced regulatory environment for availability and advertising in our country, the focus on increasing taxation detracts from attention to other worthwhile and impactful target areas as outlined in the working document. Furthermore, unregulated manufacturing, can pose an important health risk to consumers as was encouraged. Emphasis needs to remain on behaviour and the harmful use of alcohol.

CONCLUSION

The policy environment has continued to progress gradually in favour of harm reduction. We have seen this from a number of policy interventions introduced in our country. We believe that their focus should be on overall effectiveness and not solely on cost effectiveness.

Yours faithfully



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Scottish Alcohol Research Network (SARN)

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

URL: <https://www.sarn.ed.ac.uk>

Submission

We suggest four key points to strengthen the draft action plan:-

1) The role of economic operators

We strongly agree that economic operators should “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. (They) 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” (p.12).

However, in some sections of the document, economic operators are given equal standing to other stakeholders, such as civil society and other UN organizations. Alcohol adversely impacts 13 of the 17 UN Sustainable Development Goals

(https://www.euro.who.int/__data/assets/pdf_file/0008/464642/Alcohol-consumption-and-sustainable-development-factsheet-eng.pdf) yet 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 / building research capacity

SARN builds capacity in alcohol research at a local, national and international level. SARN members contribute to the research evidence base which allows policymakers to effectively tackle alcohol-related harm, and provides NGOs with robust evidence for advocacy. We therefore support the objective to “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” (p.9).

However, we 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. 2017), rapid literature reviews and ‘reviews of reviews’ on emerging issues (e.g. Atkinson et al. 2019; Fitzgerald et al. 2016), and using innovative methods to understand the lived experience of drinking across the harm continuum (Shortt et al. 2017), as well as more conventional epidemiological research.

Attachment(s): 1

00267_47_sarn-who-global-action-plan-response.pdf



Scottish Alcohol Research Network (SARN) 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 (7 December 2020)

We suggest four key points to strengthen the draft action plan:-

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We strongly agree that economic operators should *“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. (They) 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”* (p.12).

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About SARN

The Scottish Alcohol Research Network (SARN) aims to promote a strong collaborative research forum for clinicians, academics and researchers with an interest in responding to alcohol-related harm in Scotland. The network consists of clinicians, academics, researchers, and relevant others with an interest in alcohol-related harm research. Participating organisations include academic institutions from across Scotland, Scottish Health Action on Alcohol Problems (SHAAP), Alcohol Focus Scotland (AFS), ScotCen Social Research, British Liver Trust, and Public Health Scotland.



Website: www.sarn.ed.ac.uk

Twitter: [@SARNalcohol](https://twitter.com/SARNalcohol)

Contact: Christopher Graham, c.graham@rcpe.ac.uk, SARN Co-ordinator

Scottish Families Affected by Alcohol & Drugs

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

URL: www.sfad.org.uk

Submission

About Scottish Families

Scottish Families Affected by Alcohol and Drugs is a national charity which supports anyone concerned about someone else's alcohol or drug use in Scotland. We were established in 2003 by family members themselves who came together to support each other and to campaign for recognition. We provide both national and local services. Each year we reach family members from all of Scotland's 32 council areas.

We provide information and advice to many people and help them with confidence, communication, general wellbeing, and we link them into local support. We also help people recognise and understand the importance of looking after themselves. Most people who engage with our service access support via our national helpline and direct support services.

Our 'Change Will Come' Strategy (2020-23) identifies 12 Key Changes which we want to see in the next 3 years. As well as these Key Changes, we will continue to develop and improve all of our existing services and activities. We will know we have succeeded when we have no more hidden families

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.

It is vital that this plan is right to ensure we have the measures in place to protect those most vulnerable to alcohol harm. This is particularly important now given the alcohol industry has the means, influence and capability to normalise alcohol products to new demographics through digital marketing, limited regulation and lack of accountability. The presence of alcohol in every day life is a consistent concern for many families currently living with problem alcohol use and those supporting recovery. It is a consistent reminder that alcohol it is never too far away and still far too accessible.

Attachment(s): 1

00439_72_sfad-who-gas-final.pdf



Scottish Families Affected by Alcohol & Drugs
Edward House, 199 Sauchiehall Street, Glasgow, G2 3EX
CEo@sfad.org.uk
8th 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.

About Scottish Families

Scottish Families Affected by Alcohol and Drugs is a national charity which supports anyone concerned about someone else's alcohol or drug use in Scotland. We were established in 2003 by family members themselves who came together to support each other and to campaign for recognition. We provide both national and local services. Each year we reach family members from all of Scotland's **32** council areas.

We provide information and advice to many people and help them with confidence, communication, general wellbeing, and we link them into local support. We also help people recognise and understand the importance of looking after themselves. Most people who engage with our service access support via our [national helpline and direct support services](#).

Our '[Change Will Come](#)' Strategy (2020-23) identifies 12 Key Changes which we want to see in the next 3 years. As well as these Key Changes, we will continue to develop and improve all of our existing services and activities. We will know we have succeeded when we have no more hidden families

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 supported 1,927 family members across our services in 2019-2020 and reached family members from all 32 council areas of Scotlandⁱ. Alcohol remains the most common source of concern for families who reach out to us through our helpline and web chat services. There was a 122% increase (312 to 693) in alcohol-related contacts to our helpline reported between March and November 2020. Two-thirds of those who contacted us in this period said their loved one was not engaged in any form of treatment or care service. There were 61 instances of domestic violence reported for the same period and a high proportion of contacts relate to alcohol withdrawal where the family or individual has no money to purchase alcohol.

With an estimated '*4% of the Scottish population thought to be alcohol dependant*'ⁱⁱ representing approximately 280,000 people, based on current population levels, many families remain hidden and unsupported living with the impact of problem alcohol use.

From our contact with families every day we know problematic alcohol use can have a lasting and significant impact on families often causing emotional distress that impacts on overall health and wellbeing. This can range from feeling unsafe in the home or in the community and having increased anxieties around the health, wellbeing and life chances for those they care for.

In 2019, 1020 people died from alcohol related causes in Scotland with over 10,000 people dying from alcohol related causes over the past decadeⁱⁱⁱ. Each life represents a network of family and friends left to cope with the impact of each preventable loss of life. Much of the harms and challenges families face can be directly linked to the presence of alcohol in everyday life and how visible, accessible and affordable alcohol is in communities across Scotland.

At Scottish Families we continue to recognise and support an emphasis on each and every country implementing a range of evidence-based policies and interventions (i.e. SAFER/WHO best buys). Whole population measures that have been proven to be effective in limiting the presence of alcohol in our homes and communities and driving down the harms experience by individuals, families and communities.

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.

It is vital that this plan is right to ensure we have the measures in place to protect those most vulnerable to alcohol harm. This is particularly important now given the alcohol industry has the means, influence and capability to normalise alcohol products to new demographics through digital marketing, limited regulation and lack of accountability. The presence of alcohol in every day life is a consistent concern for many families currently living with problem alcohol use and those supporting recovery. It is a consistent reminder that alcohol it is never too far away and still far too accessible.

Thank you for your consideration.

Yours sincerely,

Justina Murray
CEO
Scottish Families Affected by Alcohol and Drugs

ⁱ <https://www.sfad.org.uk/content/uploads/2020/06/Impact-Report-2019-2020.pdf>

ⁱⁱ <https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse>

ⁱⁱⁱ <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-deaths>

SCOTTISH GOVERNMENT

Department/Unit: *DIRECTORATE GENERAL FOR HEALTH & SOCIAL CARE*

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

Submission

SCOTTISH GOVERNMENT

1. The Scottish Government (SG) welcomes the opportunity to comment on the World Health Organization consultation regarding further implementation of the ground-breaking 2010 Global Alcohol Strategy.
2. The SG established a national alcohol strategy for Scotland in 2008. Without exception, the SG has had a policy in place since then to reduce alcohol consumption and reduce the related alcohol harms to individuals, families, communities and wider society in Scotland.
3. The current SG alcohol policy documents, Alcohol Framework (2018) and Rights, Respect and Recovery (2018), together follow the WHO 'Best Buys' and 'SAFER' models, recognising that these are the internationally accepted, evidence-based approaches which will work to reduce alcohol harms, if implemented effectively. The SG suggests strengthening the language in the next version of the document to very clearly reflect the Best Buys and SAFER.
4. The SG sets out its alcohol policies in written form to provide clarity to citizens and elected officials/institutions, and to ensure appropriate scrutiny of approach and delivery against its ambitions. The SG therefore supports the WHO aim of encouraging further development of written alcohol policies across all countries with a stretch target as proposed in 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."
5. The SG takes a 'whole population approach' to alcohol and so recognises the impacts of consumption at the national level and across different population subgroups, beginning from small scale consumption which can impact on, for example, cancer risk or harm to an unborn child through Fetal Alcohol Spectrum Disorders. To this end, the SG suggests that the consultation document's focus on 'harmful use' of alcohol could be framed more effectively in terms of the harms caused by consumption, given that the international evidence base has established there is no safe level of consumption.

Scottish Government

12 December 2020

Attachment(s): 0

Scottish Health Action on Alcohol Problems (SHAAP)

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

URL: shaap.org.uk

Submission

SHAAP applauds the WHO's commitment to tackling the harmful use of alcohol and the continued attention that the WHO has dedicated to the issue. The overall scope of ambition shown by the WHO through this working document is to be commended and SHAAP looks forward to playing our part in supporting the implementation of the action plan in the coming months.

SHAAP, however, has a number of concerns with the current working document. These include its density and length, and how this may affect the feasibility of its often overlapping proposed actions. We also note a lack of clarity regarding accountability for implementation, and time intervals for review and reporting on implementation of the action plan in the working document. Further, we are in agreement with the Global Alcohol Policy Alliance (GAPA) and European Alcohol Policy Alliance (Eurocare) that the action plan should focus more on high-level alcohol policy 'best buys' and the recommendations of WHO's SAFER initiative.

Attachment(s): 1

00269_48_who-consultation-on-an-action-plan-for-implementation-of-the-global-strategy-to-reduce-the-harmful-use-of-alcohol-shaap-response-draft-v2.pdf



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*: Scottish Health Action on Alcohol Problems (SHAAP) response

About SHAAP

Scottish Health Action on Alcohol Problems (SHAAP) is a partnership of the Medical Royal Colleges in Scotland and the Faculty of Public Health and is based at the Royal College of Physicians of Edinburgh (RCPE). SHAAP provides the authoritative medical and clinical voice on the need to reduce the impact of alcohol-related harm on the health and wellbeing of people in Scotland and the evidence-based approaches to achieve this.

Introduction

SHAAP welcomes the opportunity to provide feedback on the World Health Organization (WHO)'s *Working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol*. As the working document itself states, implementation of the strategy has been uneven across WHO regions since its endorsement in 2010, and between 2010 and 2018 there has been little progress in reducing per capital global alcohol consumption. Globally, the overall burden of death and disease attributable to alcohol remains unacceptably high.

SHAAP applauds the WHO's commitment to tackling the harmful use of alcohol and the continued attention that the WHO has dedicated to the issue. If we are to see impactful change then there must be global leadership on alcohol harm reduction and the WHO is ideally placed to continue to lead this work. The overall scope of ambition shown by the WHO through this working document is to be commended and SHAAP looks forward to playing our part in supporting the implementation of the action plan in the coming months.

Scotland, where SHAAP is based, has been an international leader in advancing evidence-based alcohol policies that protect people's health. We have a clear national framework for tackling alcohol-related harm that draws on many of the policies embedded in 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. Last year 1,020 people died from an alcohol-specific cause – a number that does not include deaths where alcohol has contributed, such as suicide, road accidents and a wide range of diseases including cancer¹. There is still much work to be done in reducing alcohol-related harm in Scotland, and the development of this action plan represents a positive step in this direction, as well as in ongoing and much needed efforts to reduce alcohol harm globally.

¹ National Records of Scotland. 2020. [Vital Events – Deaths – Alcohol Deaths – Alcohol-specific deaths: main points](#).

SHAAP, however, has a number of concerns with the current working document. These include its density and length, and how this may affect the feasibility of its often overlapping proposed actions. We also note a lack of clarity regarding accountability for implementation, and time intervals for review and reporting on implementation of the action plan in the working document. Further, we are in agreement with the Global Alcohol Policy Alliance (GAPA) and European Alcohol Policy Alliance (Eurocare) that the action plan should focus more on high-level alcohol policy ‘best buys’ and the recommendations of WHO’s SAFER initiative.

Finally, we are concerned by the inclusion of ‘Economic Operators’ – i.e. producers, distributors, retailers and marketers of alcohol products – as stakeholders with equal standing alongside civil society, academics and other UN organisations in the working document. These economic operators have a clear conflict of interest when it comes to the majority of actions identified by the action plan – actions that are urgently needed in order to reduce the burden of death and disease attributable to alcohol globally. 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.

Role of economic operators

SHAAP is concerned about 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 operators have a clear conflict of interest in relation to the majority of actions identified by the action plan as necessary to the effective implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. To include them in this working document as stakeholders with equal standing alongside (e.g.) civil society and major partners within the UN system – particularly whilst using the language of “invitation” when it comes to suggestions regarding proposed actions that they may take to help reduce alcohol harm – sends deeply contradictory messages, and risks severely undermining both the standing of the action plan, and the feasibility of implementing it in the long run.

This is especially true, given that the working document makes clear at several points that one of the major challenges to the effective implementation of the Global Strategy so far has been the influence of “powerful commercial interests” in policy-making and implementation, and commercial messaging about alcohol as part of “poorly regulated marketing”. 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 (AHA), for instance, found that 70% of labels reviewed on alcohol products still did not include the official, up-to-date low-risk drinking guidelines recommended by England’s Chief Medical Officer (CMO), more than three years after they were updated. 98% of the products of members of the Portman Group – an industry funded “social responsibility body” that considers itself a “leader in best practice” – did not include the correct low-risk guidelines². 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.

While SHAAP supports the philosophy of dialogue with the industry in order to more fully understand the levers of change to reduce alcohol harm, we are not convinced that the manner in which this “invitation” to dialogue is currently framed within the working document will yield productive results. Indeed, alcohol industry involvements in partnership arrangements with the Scottish

² Alcohol Health Alliance UK. 2020. [Drinking in the dark: How alcohol labelling fails consumers](#).

Government have not led to any substantial progress on actions that might help reduce alcohol-related harm in there, such as the provision of detailed sales and marketing data. Given the failure of economic operators to contribute meaningfully in areas such as this, where they could potentially contribute to the reduction of alcohol-related harm through increased transparency, alongside their continued failure to effectively self-regulate in areas such as alcohol marketing and labelling, it is SHAAP's position that 1) they be addressed in a separate section of the action plan, and their conflict of interests made clear, 2) that the language used to refer to dialogue with the industry in the action plan be reassessed, and 3) that the WHO secretariat should evaluate the effectiveness of its regular face-to-face dialogue with the alcohol industry.

Need for more focus on high-impact strategies and interventions/SAFER initiative

The action plan needs a clearer emphasis on elevating the implementation of the most cost-effective and effective 'best buy' policies to reduce alcohol-related harms as its focus, particularly those included in WHO's 2018 SAFER initiative. The current working document is lengthy and dense, and the numerous, often overlapping recommendations have the effect of obscuring this focus.

It is therefore SHAAP's position that the action plan should be restructured to make clear that Action Areas 2-6 should all ideally facilitate and support the effective implementation of Action Area 1: Implementation of High-Impact Strategies and Interventions. Restructuring the action plan in this way would both condense it – making it more accessible, as well as bring clarity to the basis on which its objectives can be achieved – making it more feasible. In line with this position, we endorse GAPA's suggestion that monitoring indicators included in the action plan should include specific metrics of SAFER implementation, and countries' reporting of the implementation of SAFER policies should be facilitated as part of the plan, especially in LMICs.

Further, it is SHAAP's position that there is scope within the working document to either include or adapt language regarding specific areas and opportunities for reducing the harmful use of alcohol. For instance:

- There is currently no mention of how exposure to alcohol during pregnancy can impair brain development of the fetus and lead to the development of Fetal Alcohol Spectrum Disorders (FASDs), or any suggestion that awareness-raising activities around alcohol harm should include raising awareness of the risks of consuming alcohol during pregnancy.
- It is SHAAP's position, following that of our partners at Eurocare, that the language used in relation to marketing in the action plan should refer to the 'exposure' of audiences to alcohol marketing, rather than their 'targeting'. For instance, there is strong evidence to show that, regardless of whether young people are being specifically targeted by alcohol advertising and sponsorship activities, their exposure to alcohol advertising affects both their attitudes towards and later consumption of alcohol³. This is important, because it underscores how all alcohol advertising, marketing and sponsorship can have a negative impact on children and young people, regardless of whether this advertising, marketing and sponsorship is specifically targeted at them. It also highlights how the current actions "invited" of economic operators in the working document – e.g. "to contribute to the elimination of marketing and sales of alcoholic beverages to minors and targeted commercial activities towards other high-risk groups" are insufficient.
- There should be more acknowledgement of alcohol as "no ordinary commodity" throughout the action plan.

³ Cf. Critchlow N, MacKintosh AM, Thomas C, et al. 2019. [Awareness of alcohol marketing, ownership of alcohol branded merchandise, and the association with alcohol consumption, higher-risk drinking, and drinking susceptibility in adolescents and young adults: a cross-sectional survey in the UK](#). BMJ Open;9:e025297. doi: 10.1136/bmjopen-2018-025297

Lack of clarity regarding accountability and time frames

SHAAP is in agreement with 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 therefore endorse the recommendation of GAPA, that the Director-General be requested to report to the World Health Assembly biennially on the progress of the implementation of the Global Action Plan. Further, we are in agreement with our partners Eurocare that there needs to be more detail about transparency around WHO processes incorporated into the action plan, particularly when it comes to records of meetings with organisations, operators and individuals who may have a stake in policymaking and the implementation of the action plan and Global Strategy. There should also be more detail in the action plan regarding accountability for reporting, and timescales for this reporting.

Finally, it is SHAAP's position that the action plan should acknowledge and link in with WHO regional plans to reduce the harmful use of alcohol, and that the inclusion of actions directed to regional political bodies (such as the European Union) and WHO regional offices should be considered.

As our partners at Eurocare state in their own consultation response, WHO regional offices are important for technical support to Member States in areas such as tracking trends in alcohol consumption, estimating the financial and health costs of alcohol harm, and providing up-to-date evidence on the effectiveness of different alcohol control policy interventions. Addressing their role in a final version of the action plan, and linking to regional plans to reduce the harmful use of alcohol should therefore be considered.

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.

Scottish Recovery Consortium

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

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

Submission

Please refer to letter

Attachment(s): 1

00194_17_who-gas-letter.pdf

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 Scottish Recovery Consortium (SRC) is a nationally commissioned independent charity which 'Supports, Represents and Connects' Lived Experience Recovery Organisations (LEROs), individuals in recovery from substance dependency issues and organisations in Scotland with an interest in recovery.

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.

SRC recognises the harms caused by alcohol across the entirety of Scotland. The damage to mental and physical health, life chances, beneficial family and social relationships, employment, involvement with criminal justice agencies and housing and homelessness are all areas that are directly impacted by alcohol harms in our small country. When we examine how alcohol affects Scottish society through a family lens then there is not one Scottish family not touched by alcohol harms.

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.

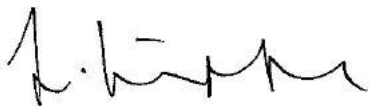
There are also areas where the action plan can be strengthened, including:

- 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.

Scotland needs the WHO action plan to help us address a societal blight and cultural indifference to the harms that can potentially be visited upon every person who uses alcohol.

Thank you for your consideration.

Yours sincerely,



Jardine Simpson
Chief Executive

Sierra Leone Alcohol Policy Alliance (SLAPA)

Country/Location: Sierra Leone

URL: www.slapasl.org

Submission

Support to LMICs to Implement the Action Plan:

LMICs lack adequate resources for the full implement the SAFER interventions and policy and legal interventions. The lack of resources is likely to expose LMICs to industry interference. SLAPA recommends that the Action Plan should consider targeted mobilization of both technical and financial support LMICs to implement the SAFER initiative, free of commercial interest. For example, the lack of adequate resources continues to slow down the enforcement of drink driving counter measures of the Sierra Leone Road Traffic Act of 2007.

Attachment(s): 1

00443_75_sierra-leone-alcohol-policy-alliance-statement-on-the-action-plan-to-reduce-the-harmful-use-of-alcohol.pdf

Statement from Sierra Leone Alcohol Policy Alliance on WHO consultation on the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

The Sierra Leone Alcohol Policy Alliance (SLAPA) 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. SLAPA also urges your office to consider these issues in your own submissions.

Support to LMICs to Implement the Action Plan:

LMICs lack adequate resources for the full implement the SAFER interventions and policy and legal interventions. The lack of resources is likely to expose LMICs to industry interference. SLAPA recommends that the Action Plan should consider targeted mobilization of both technical and financial support LMICs to implement the SAFER initiative, free of commercial interest. For example, the lack of adequate resources continues to slow down the enforcement of drink driving counter measures of the Sierra Leone Road Traffic Act of 2007.

11th December 2020

Sierra Leone Alcohol Policy Alliance

SIFASD, Società Italiana sulla Sindrome Feto-Alcolica

Country/Location: Italy

URL: www.sifasd.it

Submission

The Italian Society on Fetal Alcoholic Syndrome suggests:

1. Fetal Alcohol Spectrum Disorders is not specified in any part of the paper. We retain that this is a significant issue! Prenatal alcohol exposure is the leading cause worldwide of congenital cognitive impairment, and it is 100% preventable.
2. To urge the Member States to introduce alcohol, and the Drug Use Disturbs in the Degree courses of professional people that have to employed in health and social professions.

Attachment(s): 1

00211_30_risposta-oms.pdf

The SIFASD (Società Italiana sulla Sindrome Feto-Alcolica - Italian Society on Fetal Alcoholic Syndrome).

The ***Italian Society on Fetal Alcoholic Syndrome*** was founded in July 2010 as a consequence of epidemiological studies in collaboration with National Institute on Alcohol Abuse and Alcoholism (NIAAA-NIH) in Latium Region of Italy 2005-2006). These studies (Aragón et al., 2008; Kodituwakku et al., 2006; May et al., 2011, 2006; Tarani et al., 2011) evidenced a prevalence of FASD in Italy of 4,8 %. In Italy, it is a growing concern in different professions and the general population. Our goals are to improve awareness of the risks of drinking alcoholic beverages during pregnancy; to improve translational research and share information with health caregiving, spread information and formation course for caregivers. SIFASD is allied with ***European Fetal Alcohol Spectrum Disorders Alliance*** (EUFASD).

Introduction

We are happy that the WHO is working to improve the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol and we look forward to working together with the WHO to reduce alcohol-related harm, especially Fetal Alcohol Spectrum Disorders.

About preliminary document of WHO, we suggest the following observations:

1. Fetal Alcohol Spectrum Disorders is not specified in any part of the paper.

A large number of research support that prenatal alcohol exposure may be associated with physical and intellectual deficits appearing only later in childhood. Prenatal alcohol exposure 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 have to be zero.

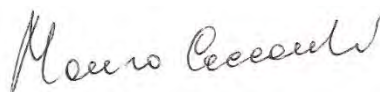
We realize that the focus of this document is on implementation of the Strategy on alcohol. However, we note that when examples of harms are given, Fetal Alcohol Spectrum Disorders are not mentioned at all. We emphasize that alcohol exposure at any time during and before the pregnancy poses a risk to the normal brain development of the fetus. Prenatal alcohol exposure, in women and men (Ceccanti et al., 2016; Conner, Bottom, & Huffman, 2020), may be associated with physical and intellectual deficits that appear only later in childhood. Prenatal alcohol exposure 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, in women, the safe amount of alcohol during the conception period and pregnancy don't exist. Recent studies showed epigenetic alcohol influence is transmissible. The consequences persist for two generations in men and three in women (Cheong, Wlodek, Moritz, & Cuffe, 2016). Prenatal exposure to alcohol causes lifelong damages and predisposition to have alcohol misuse, increasing the risk of alcohol health and social consequences.

Throughout the WHO document, we share the Eufasd Alliance suggestions aimed at including this critical aspect of alcohol-induced problems, affecting not only women with DUA, but also women who continue to drink even minimal amounts of alcohol during pregnancy.

2. About alcohol implementation strategies:

We agree with the efforts described in the text to improve the actions towards advertisements. Moreover, we suggest dedicating some paragraphs to urge the Member States to introduce alcohol, and the Drug Use Disturbs in the Degree courses of professional people that have to employed in health and social professions. In our knowledge, a large number of student, 20-25-year-old, had alcohol problems, and only a few have consciousness of their alcohol problems (Battagliese et al., 2017): how is it possible for them to have care of their patients or clients?

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Il Presidente
Prof. Mauro Ceccanti

Sindicato Nacional da Indústria da Cerveja

Country/Location: Brazil

Submission

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 in the last year. Although still above the world average per capita consumption of 6.4 L/year, 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. Among drinkers, the average consumption is 3 doses / day, higher than the average in the Americas region and worldwide, of 2.3 doses/day. 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.

Even though we share the same understanding of the working document that alcohol harmful use is a complex theme, with multi factorial causes and this characteristic makes tackling the situation much more difficult, at several passages, the working document brings contradictory statements regarding the need of the enrollment of all actors for the success of the Global Strategy (GSA).

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Attachment(s): 1

00370_33_2020.dez.11.sindicerv.submission-to-who-gsap-consultation.pdf



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 Beer Trade Union (SINDICERV) represents 80% of the Brazilian beer market, the most consumed alcoholic beverage in the country. In Brazil, beer represents a sector that contributes with 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, we welcome 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 reinforcement and improvement of the Global Strategy Policies set the understanding of the harmful alcohol use has a multifactorial cause and thus strategies and Public Policies must enroll the whole society level, including economic operators.

10 years of Global Strategy: the Brazilian advances

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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.

Even though we share the same understanding of the working document that **alcohol harmful use is a complex theme, with multi factorial causes** and this characteristic makes tackling the situation much more difficult, at several passages, the working document brings contradictory statements regarding 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.

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 responsible consumption 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 below 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.

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.

SINDICERV 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

There is no evidence that even with economic interest on alcoholic beverage commercialization, the sector conflicts in 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, excluding 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 (Li et al, 2018; Kunzmann et al, 2018; Ronksley et al, 2011) and is part of many cultures around the world since the beginning of societies.

Li et al. Circulation. 2018;137:00–00. DOI: 10.1161/CIRCULATIONAHA.117.032047

Ronksley et al. BMJ 2011;342:d671

Kunzmann et al.PLoS Med 2018; 15(6): e1002585

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.

In addition, the UN itself, through UNESCO, granted Belgian brewing culture the recognition of Intangible Cultural Heritage of Humanity in 2016. The complexity involved in the relationship between man and alcohol requires a multidimensional vision to capture the nuances of this process, by which humanity has had immemorial connections since the pre-agricultural revolution.

UNESCO (2016) Available at: <https://ich.unesco.org/en/RL/beer-culture-in-belgium-01062> *Pages 7, 97, 101, 102, 114.

Strong evidences recommend alcohol policies to nudge consumers toward lower alcohol strength options as an effective and cost-effective way to reduce harmful use of alcohol and the working document misses the opportunity to take this relevant strategy into consideration.

Pricing and taxation have for long being discussed on WHO's documents as relevant cost-effective strategy to tackle harmful alcohol use, these strategies could be cost-effective and successful once they have the potential to nudge consumers toward lower alcohol strength beverages and thus, reduce the total alcohol consumption. The present working document could incorporate into robust scientific evidence on this matter.

Before implementing SAFER policies, local governments must take into consideration the local peculiarities as the beverage preference, socio economic status of the population and the availability of other sources of alcohol (for example, illicit or unrecorded alcohol).

We present bellow essential references for appreciation over pricing policies.

Strategy already recognized by WHO:

Several WHO's document, result from extensive literature review, states that policies that drives consumers for the option of beverages with lower alcohol concentrations are relevant Public Policies, specially for lower income countries:

- WHO Global Status Report: Alcohol Policy (2004)

*[I]n some countries, **the official policy of the pricing system is to steer people towards a particular type of low-alcohol or non-alcoholic beverage, in order to substantially reduce risky or high blood alcohol levels***

- WHO Public health successes and missed opportunities: Trends in alcohol consumption and attributable mortality in the WHO European Region (2016)

"Taxation is one important tool of an alcohol policy, and different taxation schemes can be used for different purposes, such as switching beverage preferences."

- WHO Global Strategy to reduce the harmful use of alcohol (2010) – Annex II

A "[h]arm reduction approach can" be supported by stronger promotion of products with a lower alcohol concentration"

- WHO Resource tool on alcohol taxation and pricing policies (2017)

"Spirits should be taxed at a higher rates because the production cost is less than the production cost for beer and wine"

"In some countries, such as China, the government may wish to discourage the troublesome tradition of the consumption of heavy spirits."

Taxation policies that result on the increased price for distilled beverages - with alcoholic volumes as higher as 40% (eg. gin, vodka, whiskeys or the Brazilian cachaça) - compared to lower alcoholic strength beverages as beer and wine, do result on a reduced total alcohol consumption by the population.

In practice, influencing consumer choice through taxation is carried out, for example, by applying different excise rates according to different beverage categories, as well as within categories, according to alcohol strength. This can nudge the heaviest drinkers to shift to lower-strength options, reducing harmful consumption:

“Consistently heavy drinkers ... systematically purchase a different mix of products than lighter drinkers; on average, they buy stronger and cheaper varieties of alcoholic beverages. We find that they are much more willing to switch between different alcohol products in response to price changes, and are less willing to switch away from alcohol altogether than lighter drinkers.

“By levying a relatively high tax rate on strong spirits the planner is able to target a larger share of the alcohol purchases of heavy than light drinkers, and is able to encourage them to switch to less strong alcohol products, hence lowering their level of ethanol consumption should target the drinking behaviors that are most costly to public health and society.” **Griffith, Rachel, Martin O’Connell, and Kate Smith. "Tax design in the alcohol market." *Journal of public economics* 172 (2019): 20-35.**

Scientific publications by experts recognized by the WHO

The general assumption that the focus should be on the total alcohol consumption and not the type of beverage has shown to being disproved by several experts. Instead, the evidence supports the common-sense recognition that rapid consumption of highly concentrated alcohol creates a greater risk for outcomes like alcohol poisoning and accidents:

Rehm, Jürgen, and Omer SM Hasan. "Is burden of disease differentially linked to spirits? A systematic scoping review and implications for alcohol policy." *Alcohol* 82 (2020): 1-10.

Kueng, Lorenz, and Evgeny Yakovlev. "The Long-Run Effects of a Public Policy on Alcohol Tastes and Mortality." Available at SSRN 2776422 (2019).

Korotayev, Andrey, et al. "Distilled spirits overconsumption as the most important factor of excessive adult male mortality in Europe." *Alcohol and Alcoholism* 53.6 (2018): 742-752.

It is important to make the disclaimer that the cited findings do not support any health related claims for lower alcohol content beverages or that these beverages are “healthier”, however, they shows that the drinking pattern and the high concentration of alcohol in some beverages types do impact differently the health outcome. Since these publications became available after the Global Strategy launch (2010), there is now the opportunity that the present review includes updated research on the theme.

Many countries have already implemented pricing policies focusing the shift of preferences from high alcohol strength beverages to lower alcohol ones. The most relevant case is Russia that observed a decrease of mortality and increase of life expectancy at the same time beer consumption increased by 78% and spirits consumption decreased 48%.

The Global Strategy action plan presents an opportunity to align with current evidence and propose policies that nudge consumers by design rather than by accident. In short, nudging consumers toward lower-alcohol products is a widespread, successful practice that is also an evidence based, effective, and cost-effective way to reduce harmful use of alcohol – and it must be incorporated into the Global Strategy action plan

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.

Available at: <https://ioqt.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

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.

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 OMS 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.

Sober World

Country/Location: United States of America

URL: www.soberworld.org

Submission

The current strategy of immediate and reactive punitive measures (laws, taxes, age restrictions, marketing controls) have limited efficacy. All these strategies are dealing with the "symptom" of self-medicating. We would suggest for consideration a more proactive approach, since humans seek positive rewards and these are longer lasting than punishment.

CHANGE THINKING. The last few decades have seen an exponential growth in mental stimulation from excessive screen time, and the brain neurotoxin is being used to counteract the excessive mental stimulation. The problem is that both activities drive Dopamine, and addictions. Teach and Market a message of LESS IS MORE and a more Fundamental Happiness - in alignment with our natural brain function.

SCHOOLS - We encourage self awe of the amazing technological wonder in the mirror. This promotes self respect and self care. Instead of talking to kids about "dangers" - encourage they learn to "optimize" and "energize" and not be drawn in by the toxins in the world like sugars and other stealth addictions.

MARKETING - A overall campaign to improve health is needed to counteract the deception of the Industry. Encourage people to better their lives, by not ingesting the poison. We want to show how limiting Alcohol is, and how to live better without it.

Attachment(s): 2

00060_04_sw-support-one-pager.pdf

00060_05_less-is-more-one-pager.pdf

SOUTHERN AFRICAN ALCOHOL POLICY ALLIANCE- LESOTHO CHAPTER

Country/Location: Lesotho

URL: saapa.net

Submission

THE DELAY CAUSED BY POLITICAL INSTABILITY IS A MAJOR CONCERN FOR THE DELAY OF HEALTH ORIENTED ALCOHOL POLICIES AND THE DIFFERENT INTERESTS OF POLITICIANS MAKES THE PROCESS TO BE MORE CHALLENGING.

Attachment(s): 1

00494_18_saapa-lesotho-who-submission-converted.pdf

SAAPA Lesotho –

Lesotho has been battling to rewrite the National Alcohol Policy since 2014 without success. Many factors have delayed this process in particular, politics; rapidly changing governments and key officials have created a confusion of the work. Some politicians voted for the enactment of the national alcohol policy during their reign but some do not support it at all. This has caused a violation of process.

Recently the Ministry of Finance has proposed a 15% Alcohol Levy but the process has been delayed because of the Alcohol Industry interference. The Alcohol Industry is using Parliamentarians to defer the process. Also, the Ministry of Finance and the Ministry of Health is not collaborating in this issue because the Ministry of Health says the money collected should be used for prevention programs but the Ministry of Finance says the levy collected will add funds to the government treasury and this causes disagreement among the government Ministries.

Lesotho has had an astonishing rise of road crashes. Lately, there is an alarming rate of drunk driving; in one recent incident a drunk driver crashed into a family car in the early hours of the morning killing four members of one family who were travelling to see a sick family member in hospital.

The nation however experienced quality of life during COVID 19 lockdown. “...since the closure of alcohol sales the rates of violence, car crashes, rape and killings of people have decreased” said Chief Thesele Maseribana a Minister of Communications during his appointment as Chairperson of National COVID-19 Secretariat (NACOSEC). These sentiments are reflected in the experience of ordinary people. In an interview with an elderly man age 50 years he said his medical records has improved positively since his Blood Pressure ratings became low during lockdown because he did not consume alcohol during that period. He added that most men he attended the clinic check-up with had the same good results so much that their Medical attendants were impressed by the lockdown period that it has brought positive change in the health of their patients. The man further said that during lockdown he had time to spend with his kids and family rather than the time he used to spend in public bars. He said he believes that spending time with his family and kids has exerted good influence on his blood-pressure because he had a good time to play with his kids and chat with them. Basotho have seen how reduced alcohol availability can avoid cases like the 13 year old girl who got pregnant due to alcohol indulgence who lives in the capital of Maseru. Moreover, the noise caused by late night alcohol sales is a heavy social burden to citizens who have built their homes near bars and pubs but the new norm has brought so much stability and peace to the citizens. COVID-19 has introduced a possibility of a new norm that alcohol can only be sold on off-premises or off-sale basis there is no more sitting at the bar and drinking there until late.

Southern African Alcohol Policy Alliance

Department/Unit: *Regional*

Country/Location: South Africa

URL: www.saapa.net

Submission

SAAPA supports the focus on the SAFER package. SAAPA recommends that economic actors do not have a role in the implementation of the global strategy. The document affords economic equal status. Reference to economic actors should be referred to a specific paragraph and outline limited roles. Conflict of interest is a major stumbling block to policy development and implementation in Southern Africa. Member countries should be supported to adopt a COI policy. The current dialogues with economic actors is not in the the interest of public health and should discontinue.

Attachment(s): 1

00386_42_saapa-who-submission-final.pdf



SAAPA statement regarding WHO consultation on the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

4 December 2020

SAAPA welcomes the opportunity to make a submission on the WHO working document for a strengthened action plan to implement the Global Strategy to Reduce the Harmful use of Alcohol.

SAAPA submits the following contextual considerations we believe needs to be taken into account in the finalisation of the action plan that should promote increased technical support and resources to governments in the Southern African region to adopt and implement evidence-based policies.

1. The 2018 WHO Global Status on Alcohol and Health lists the Afro region as having the highest of age standardised alcohol attributable burden of disease and injury. Although alcohol consumption is on the decline, HED is highest amongst drinkers in sub-Saharan African region.¹
2. The majority of citizens in the Afro region are non- drinkers, despite the perception of alcohol consumption being the social norm. This norm is promoted and fuelled by aggressive marketing by the alcohol industry in pursuance of expanding their market in the South, particularly amongst young people and in response to a decline in market in the North where consumers have become more health literate.
3. The Afro region is one of the least regulated alcohol environments globally, an advantage that the alcohol industry is wanting to protect.
4. Trade agreements and the absence of international binding instrument similar to FCTC limits the ability of governments, particularly in LMIC, to adopt more restrictive policies to regulate production, distribution and marketing alcohol products.
5. Cross border ownership of production and retail together with marketing influences the availability and affordability of alcohol in the region. A glaring example is that of SABC TV broadcasting in Botswana with their alcohol adverts, despite the regulated alcohol advertising in Botswana.
6. Retail ownership is rapidly integrated with general consumer goods retail and marketed as an 'one stop shop'. The Shoprite retail company owns 2829 stores in 15 countries across the African continent, with many having a liquor off consumption license. The retail company markets itself to the lower socio-economic market. One of their marketing campaigns are

¹ http://www.who.int/substance_abuse/publications/global_alcohol_report/en/

“Whiskey Wednesdays” and “Beer Fridays”. Consumers across the Southern African region are ‘guaranteed’ access to cheaply priced alcohol.

7. An international binding instrument will support neighbouring countries in the Southern Africa region to adopt similar policy measures and therefore reduce the transfer or spill over of trade to a less restrictive environment.
8. Industry players have capitalised on the notion of public private partnerships and have consistently positioned themselves as contributors to development and job creation despite the impact of the production process on natural resources in countries like South Africa with water shortages, and Zambia where crop production is redirected to supply alcohol production instead of food supply. In Botswana the progressive alcohol tax regime and limited hours of sale has been reduced in response to industry pressure and their argument that the policy impacts on job creation.
9. Public private partnerships pose an inherent conflict of interest and creates opportunity for the industry to influence policy decisions. For example, in Lesotho the industry actively lobbies against the proposed 15% alcohol levy. In South Africa, the statutory mechanism of the National Economic Development and Labour Council Act No. 35 of 1994² provides for the inclusion of the industry to negotiate new policies. The industry used their ‘place at the table’ to demand a socio-economic impact assessment of the draft Liquor Amendment Bill of 2017, funded it and has since then refused to accept the recommendations³ that the adoption of the Bill will reduce consumption, save lives and reduce cost of alcohol attributable harm to South Africa. This Bill is still not adopted 3 years later.
10. Alcohol attributable harm cost countries valuable resources and do not generate the revenue to the economy as claimed by the industry e.g., cost to South Africa annually is about R246 billion in comparison to the R97 billion generated through tax revenue.⁴ LMIC resources are disproportionately redirected away from development priorities to manage alcohol attributable harm.
11. In countries like Botswana, where there is a tax levy on alcohol meant to be used for promotion of projects designed to combat alcohol abuse and minimize effects of alcohol abuse, the levy is used for supporting other general activities that are not related to its original objectives. As a result, the intended outcomes remain unreached.

Specific recommendations

General

SAAPA is disappointed that the review process did not use the opportunity to extract the Secretariat from consulting the industry similar to protocols for other harmful industries. Instead the document appears to have increased the role of the economic actors and afforded them equal status by outlining actions under each target area. **SAAPA believes that the current bi-annual consultations with industry is not in the interest of public health, and is used by the industry to adapt their profit driven strategies.**

² <http://nedlac.org.za/wp-content/uploads/2017/10/NEDLAC-ACTS.pdf>

³ Genesis Analytics, 2017, Evaluating the economic, health and social impacts of the proposed Liquor Amendment Bill, 2017, REPORT PREPARED FOR NEDLAC BY GENESIS ANALYTICS

⁴ Matzopoulos, R., Truen, S., Bowman, B. & Corrigan, J., 2014. “The cost of harmful alcohol use in South Africa”. South African Medical Journal, 104(2): 127-132

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

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

The general language of the action areas is not strong enough.

The list of actions is also very long and stands the risk of very few being implemented.

SAAPA recommends that the list of actions is reduced and focused on the WHO 'best buys' and SAFER⁵ strategy.

Action Area 1

1. A reference to COI should be made.
2. Member states should be supported to adopt a COI policy.
3. A recommendation should be that the WHO Secretariat discontinue dialogues with industry. These dialogues have no binding powers and therefore do not advance a public health mandate.

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 ThaiHealth.
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 is often misinterpreted by consumers as standard unit sizes.

The Southern African Alcohol Policy Alliance (SAAPA) is a non-governmental organisation with over a 100 civil society affiliates across 6 countries – Botswana, Lesotho, Namibia, South Africa, Zambia and Zimbabwe. Our vision is to create a platform for like minded organisations to learn and share information and experiences that advocates for evidence-based alcohol policies that will promote the well-being of citizens in the Southern African region.

For more information, please contact
Aadielah Maker Diedericks
SAAPA Regional Coordinator
saapa.za@gmail.com

⁵ http://www.who.int/substance_abuse/safer/en/

Southern African Alcohol Policy Alliance South Africa (SAAPA SA)

Country/Location: South Africa

URL: www.saapa.net

Submission

1. SAAPA SA supports the submission made by our regional body, the Southern African Alcohol Policy Alliance (SAAPA).
2. SAAPA SA believes that, while it is correct that the alcohol industry and associated industries (eg advertising, media etc) should be encouraged to take steps within the confines of their own operations to reduce alcohol-related harm, this should not be interpreted as suggesting self-regulation, eg in terms of production, pricing, advertising and sponsorships, operating hours etc. Self-regulation is counter-intuitive and cannot work as it is not in the interests of the industry for it to work. Member States must therefore be encouraged to introduce measures to regulate the industry in the interests of public health and well-being. We also reiterate the view of SAAPA Regional that the references to the industry in the document be reassessed and reduced and that engagement with the industry is circumscribed and kept to an absolute minimum.
3. SAAPA SA supports the view that alcohol policy and legislation must prioritise public health. However, responsibility for policy and legislation often resides with a department (eg Economic Affairs or Trade and Industry) that does not have public health as a priority goal. Perhaps the WHO could commission a study (if this has not already been done) to determine which department is responsible for alcohol policy in each Member State and evaluate the impact of the location of the mandate on the Member State's commitment to reducing alcohol-related harm in the interests of public health. The results may be useful in assisting Member States to reassess their own practices and to consider moving the mandate to a more appropriate department. That department must be supported by the rest of government with a united commitment to the project of reducing alcohol-related harm. This would support one of the Action Area 3 priorities: "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."
4. In LMIC countries in particular, the sale of alcohol (licensed and unlicensed) is often a last resort way for someone to make a living in the absence of other viable alternatives. Member States should therefore be encouraged to actively improve and facilitate opportunities for traders and potential traders to choose other ways of generating an income for themselves, thereby contributing to a reduction in the number of outlets (and therefore availability) over a period of time.
5. Very few countries consider the human rights aspect of alcohol-related harm. We believe it would be very useful for the Secretariat to make proposals in this regard and to encourage countries to include the protection of human rights as one of the drivers of the need for better alcohol legislation. This will also help to counter arguments by libertarians and others that control over alcohol is an infringement of their basic human rights. As we all know, this has been a thorny issue during the COVID-19 pandemic.

6. SAAPA SA fully supports the call for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control as a mechanism to assist countries and civil society organisations in their efforts to put national measures in place to reduce alcohol-related harm. Such a policy should allow for effective tools for controlling the global alcohol industry.

7. "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." This assertion in the document echoes recent articles in the Lancet (VOLUME 8, ISSUE 3, E329-E330, MARCH 01, 2020 and www.thelancet.com/public-health Vol 5 June 2020). Of particular concern is that the alcohol industry has enormous resources at its disposal which it can use to promote its interests through marketing, through promoting its 'drink responsibly' campaigns, and through funding governments and civil society organisations. WHO must surely allocate for itself a key role in changing this situation, not only by encouraging increased taxes on alcohol and ring-fenced funding for alcohol harm reduction and itself providing funding for such work, but also by motivating for more investment in alcohol advocacy work by philanthropic organisations, foundations and governments, particularly for civil society organisations. This is particularly important with respect to one of the 'Operational Principles for Global Action - Empowering of people and communities'.

Attachment(s): 0

Spirits New Zealand/Brewers Association of New Zealand/New Zealand Winegrowers

Country/Location: New Zealand

URL: www.spiritsnz.org.nz

Submission

Thank you for the opportunity to provide our views on the draft Action Plan working document to Implement the Global Strategy to reduce the harmful use of alcohol. This is a joint submission from the peak bodies representing the New Zealand industry - New Zealand Winegrowers, the Brewers Association of New Zealand and Spirits New Zealand.

In short summary we are concerned the working document is trying to establish a range of approaches that seem at odds or in conflict with previous decisions made by the World Health Assembly and Executive Board. We are also concerned the working document is effectively promoting a “one size fits all” approach thus limiting the ability of Member States to choose jurisdictionally relevant harm reduction measures and lastly, and as we have communicated through our government representatives in the past, the continued focus on a reduction in per capita consumption as a key metric as opposed to harmful consumption is limiting in scope and will not provide any true insight into harmful drinking practices.

We expand on these, and other, matters in the submission uploaded below.

Attachment(s): 1

00504_25_new-zealand-submission-final.pdf

WHO Web-based Consultation on the Draft Action Plan and working document to Implement the Global Strategy to reduce the harmful use of alcohol.

New Zealand Industry Submission

Introduction

Thank you for the opportunity to provide our views on the draft Action Plan working document to Implement the Global Strategy to reduce the harmful use of alcohol. This is a joint submission from the peak bodies representing the New Zealand industry - New Zealand Winegrowers, the Brewers Association of New Zealand and Spirits New Zealand.

In short summary we are concerned the working document is trying to establish a range of approaches that seem at odds or in conflict with previous decisions made by the World Health Assembly and Executive Board. We are also concerned the working document is effectively promoting a “one size fits all” approach thus limiting the ability of Member States to choose jurisdictionally relevant harm reduction measures and lastly, and as we have communicated through our government representatives in the past, the continued focus on a reduction in per capita consumption as a key metric as opposed to harmful consumption is limiting in scope and will not provide any true insight into harmful drinking practices.

We expand on these, and other, matters below.



Jeffrey Clarke
General Manager Advocacy and
General Counsel



Dylan Firth
Executive Director



Robert Brewer
Chief Executive



Submission

1. Reference to a framework convention for alcohol not supported.

The working document states that alcohol is not subject to a framework convention. We consider the introduction of this as a matter for consideration is both unhelpful and unsupported by previous decisions of the World Health Assembly which agreed the roadmap for the Global Alcohol strategy.

We ask that references to a framework convention for alcohol be removed.

2. Industry makes a positive contribution to harm reduction and policy development.

It is unfortunate the working document makes specific note that industry should not be involved in policy development or harm minimisation measures. This is an extremely limited view as globally the alcohol industry contributes significantly and positively to the development of policies and programmes specifically designed to reduce harmful drinking.

In New Zealand for example through our social aspects charity, The Tomorrow Project, we have helped educate over 35,000 year 9 (13 y.o.) school pupils on alcohol harm reduction through the highly acclaimed Smashed theatre-based education programme. Our individual members also invest heavily in such areas.

We also note that statements made in the working document about limiting industry involvement are at odds with the High-Level Political Declaration on NCDs made in 2018 which, among other things, stated that economic operators should be encouraged “...to contribute to reducing harmful use of alcohol in their core areas”.

We ask that the references to industry being barred from any involvement in the alcohol harm debate be removed or rewritten to reflect the High-Level Political Declaration.

3. A “one-size-fits-all” approach is not supported.

We feel the promotion of the SAFER initiative as the, seemingly, only suite of harm reduction measures to be available to Member States is limiting and should be removed and replaced with a broader sweep of measures for selection based on Member States’ individual jurisdictional challenges. In particular a number of the SAFER components are simply unsuited to countries such as New Zealand which has invested heavily in policies and laws to manage the sale and supply of alcohol.

To overlay SAFER practices such as price controls, marketing restrictions, e-commerce restrictions and taxation measures on an already highly regulated area would be impractical. Additionally it is clear that such measures tend to target moderate drinkers’ behaviours

rather than the heavier drinker.^{1 2}

References in the working document for tax revenue to be tagged for alcohol harm reduction initiatives is out of step with how developed countries such as New Zealand manage such matters. In New Zealand much of this decision making has already been made through standard policy interventions. For example the New Zealand alcohol industry is levied under New Zealand law and contributes approximately \$NZ 11.5 million per annum to an agency established specifically to promote safer drinking practices. We also generate over \$NZ 1 billion in excise tax and duties to government's consolidated fund.

4. Harmful use – not per capita consumption.

We ask the working document be amended to ensure the key focus is reducing the harmful use of alcohol and not just a reduction in per capita consumption per se. To not do so would be inconsistent with the overall objectives of the Global Alcohol Strategy as agreed by Member States.

Our concerns in this area are highlighted by a number of statements made in the working document including, for example, a specific objective to reduce consumption (global target 1.2 p11). We would ask the working document be amended to include the agreed measures of reduction in harmful use - heavy episodic drinking and alcohol-related mortality and morbidity.

5. Why propose labelling standards when these are set elsewhere?

We are surprised and concerned at references in the working document for the establishment of international labelling standards to better inform consumers “...*about the content of the products and the health risks associated with their consumption.*” Our understanding is that, firstly, this has never been identified as a matter that WHO should take action on.

Secondly there is a body of work looking at this area already underway in Codex and thirdly many Member States take specific regulatory action in this area already. For example Australia and New Zealand share a set of joint food standards administered by Food Standards Australia/New Zealand (FSANZ).

A core part of this work – much of it currently under review – sets standards for labelling of alcoholic beverages including what information and messages are displayed for the benefit of the consumer.

We ask that references to labelling be removed from the working document and draft Action Plan.

¹ Byrnes, J., Shakeshaft, A., Petrie, D., Doran, C. (2012). Can harms associated with high-intensity drinking be reduced by increasing the price of alcohol? *Drug and Alcohol Review*, 32(1), 27-30.

² Nelson, J. P. (2013). Robust demand elasticities for wine and distilled spirits: Meta-analysis with corrections for outliers and publication bias. *Journal of Wine Economics*, 8(3), 294-317.

6. International trade is not a WHO remit.

We are concerned to see references to two specific actions in the draft Action Plan that purport to relate to the need to include advocacy of alcohol attributable health impacts in international trade negotiations and a reference in the working document supporting the development of a framework convention in the context of multi or bilateral trade negotiations (i.e. a framework convention would allow Member States to more freely negotiate trade deals because the need to cater for the distribution of alcohol would no longer be necessary).

We are strongly opposed to such references. Trade negotiations are the domain of Member States, not the WHO. Moreover the World Trade Organisation is the appropriate global body established to mediate trade disputes and trade matters on behalf of Member States.

We ask that references to any trade-related matters in the working document of draft Action plan be removed.

spiritsBULGARIA

Country/Location: Bulgaria

URL: www.spirits.bg

Submission

Bulgaria, Sofia: We would like to thank the World Health Organisation for its commitment to minimize and prevent the harmful drinking of alcohol of any kind, and welcome mostly all of the initiatives proposed here, moreover there are several emphasises and insists of economic operators to be strongly involved in all initiatives concerning responsible drinking behaviour, non-exposure, safeguarding of risks groups and reducing heavy episodic drinking.

In the attached feedback (one PDF) we raise some points in response to the publication of the working document on the Global Strategy to Reduce the Harmful Use of Alcohol - in four areas: Role of economic operators; Partnership, dialogue and coordination; Technical support and capacity building; and Knowledge production and information systems. Best regards, Ralica Scorcheva-Slavova

Attachment(s): 1

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20201207-74 / 7-DEC-2020
Bulgaria, Sofia

spiritsBULGARIA
feedback for consultation on a working document on
the Global Strategy to Reduce the Harmful Use of Alcohol

spiritsBULGARIA is the trade association of producers, importers and traders of spirit drinks in Bulgaria. We got thoroughly acquainted ourselves with the *Global Strategy to Reduce the Harmful Use of Alcohol* issued late November 2020.

We would like to thank World Health Organisation about its commitment to minimize and prevent the harmful drinking of alcohol of ANY kind and welcome mostly all of the initiatives proposed here, moreover there are several emphasises and insists of economic operators to be strongly involved in all initiatives concerning responsible drinking behaviour, non-exposure, safeguarding of risks groups and reducing heavy episodic drinking.

On our hand and in our role of trade association we are also fully committed to a number of important self- and co-regulatory initiatives in Bulgaria involving at-risk groups like: (1) minors and adolescents, (2) pregnant women, (3) drivers of vehicles. Some of the prevention programs we have been working on the recent years are PARENTAL MEETINGS: SMALL TALK ON BIG THEMES targeted to parents and families of 9-11 YO children to firstly explain risks of the early onset and defer as much as possible the onset age of approaching alcohol. The extension of the above is the TALK ABOUT ALCOHOL prevention program addressing the 12-16 YO adolescents and educating them, by the help of their school teachers and in safe and controllable environment about the harms of early alcohol consumption. This program gives reasonable tips to students on how to draw strength to resist the influence of peers and find motivation for a healthy, safe and sober lifestyle. Other programs that spiritsBULGARIA has been working on for years are WE DO NOT SELL ALCOHOL TO MINORS – designated to restricting the access of minors to alcohol in retail and THE BILL YOU DO NOT WANT TO PAY - for consumers in night clubs for alternative ways to go home and stress on never drive after drinking-behaviour.

Herewith, we wish to raise the following points in response to the publication of the working document on the *Global Strategy to Reduce the Harmful Use of Alcohol* and namely:

1. Role of economic operators

In our view economic operators already made significant and positive contribution to reducing the harmful use of alcohol, and in line with *WHO's Global strategy to reduce the harmful use of alcohol* they should be a sustainable body of all partnership and consecutive bodies who tackle with the problem and prevention on a national and on a global level. They should be always included, not excluded. Improving alcohol literacy or alcohol education would be one of the areas where all stakeholders could contribute. From the experience so far, our ethical codes, communication and self-regulation rules have been acknowledged and approved by the national regulatory body and taken as a good example to other industries, therefore involvement of the private sector in policy dialogue and the development of policy would be more than welcomed.

2. Partnership, dialogue and coordination (Area 3)

The promotion of “one-size-fits-all approach” as the SAFER initiative would be extremely detrimental to countries as diverse as the European ones, regardless of their needs, cultural differences and achievements in the fight against alcohol related harms. On one hand, SAFER is recommending unanimity but with exclusion of economic operators who are willing to cooperate voluntarily, from its scope of operation; on the other hand, it proposes unification of policies and approaches in all countries. We do not think that this obvious contradiction

visible even in the aim areas of the document will lead to any desired results in the fight against the harms of alcohol, but on the contrary will lead to extremely negative results.

3. Technical support and capacity building (Area 4)

Please be aware that more than necessary regulations of on-premise and off-premise alcohol outlets and counter to common trade perceptions such as licensing system on retail sales, or public health oriented government monopolies might easily lead to significant increase of illicit and/or home alcohol production that low and middle income European countries cannot easily restrict or fight, and this would somehow evidently decrease consumption per se on paper, but will harmfully affect drinking habits and responsibility as well as outstep the market constitutions in a long term.

We might say that there are in some parts of the document several references to increasing taxes on alcohol beverage in general and also for earmarked taxation on alcohol beverages to fund prevention and treatment of alcohol use disorders. It proposes a target for increasing the number of countries that have earmarked tax revenue for reducing the harmful use of alcohol. Furthermore, it 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. In our opinion, this is in contradiction with the free law will of European member states, which might have different mechanisms and/or means to claim the above or even worse would use the above as a corruption instruments towards certain economic operators.

The central claim behind calls for policies such as excise hikes is that reduced affordability of alcohol would in turn lead to reduced consumption of alcohol. However, in most of Europe, the opposite has been the case: alcohol has structurally become more affordable in recent decades (as societies have become more affluent) while the consumption per capita in Europe has steadily declined (ESPAD 2020). A blunt instrument such as a tax increase on the price of alcohol might see an initial one-off effect, but is unlikely to have a long-term impact – especially in those European countries which are expected to continue to see the standard of living and wealth of society increase in the coming years. Policies which seek to inform and educate the consumer about the importance of responsible consumption of alcohol may therefore be regarded as a more suitable tool for high-income countries. In addition, there are a number of countries in Europe who have already introduced considerable structural barriers to the availability and affordability of alcohol. In line with this, the report's suggestion that there have been "general trends towards deregulation in recent decades resulted in a weakening of alcohol controls" is not accurate – there have already been a number of restrictions on sales, advertising and marketing introduced throughout the European region, combined with a number of self- and co-regulatory initiatives pursued by producers themselves.

4. Knowledge production and information systems (Area 5)

Partnership and fairness are even more important when related to knowledge production and information systems. The idea of "effective monitoring of levels and patterns of alcohol consumption in populations and of alcohol-related harm" would be even more valuable if data collection is focused to help people with non-communicative diseases instead of demonizing alcohol consumption per se, which includes responsible for many cultures drinking patterns. For sure, the later rises the idea of sources harmonization, respect for the other's views and non-discrimination between stakeholders. And therefore we count the industry to be a useful and reliable partner in this field of operation as well.

Respectfully,

Ralica Scorcheva-Slavova, President of spiritsBULGARIA

spiritsBULGARIA - Association of Producers, Importers and Traders of Spirits Drinks

ralica.scorcheva@maxxium.bg | office@spirits.bg

spiritsEUROPE

Country/Location: Belgium

Submission

To whom it may concern,

We would like to thank you for the opportunity to contribute to this consultation.

Please find in attachment our remarks, and we look forward to further engagement with you.

All the best, and wishing you a very Merry Christmas,

Eoin Keane, on behalf of spiritsEUROPE.

Attachment(s): 1

00319_01_cp.as-091-2020-spiritseurope-response-.pdf



spiritsEUROPE response to the consultation of first draft of the Working Document on the Global Strategy to Reduce the Harmful Use of Alcohol.

spiritsEUROPE is the trade association representing the European spirits' sector.

We would like to thank the World Health Organisation for the opportunity to contribute to a *Global Strategy to Reduce the Harmful Use of Alcohol*. Our sector is strongly committed to a number of important self- and co-regulatory initiatives in Europe in key areas of the Strategy and has long invested in a broad range of responsible drinking initiatives focusing on the reduction of heavy episodic drinking, underage drinking and drink driving. These initiatives have gradually evolved in recent years in close dialogue with policymakers, scientific experts, and civil society representatives and have broadly proven to be effective and impactful. As such, we are keen to share our learnings and contribute to, the success of the Strategy with the objective of reducing the harmful consumption of alcohol. We are pleased to see the efforts and contributions of producers recognised – a whole-of-society and inclusive approach is sure to be the most successful.

We wish to raise the following points in response to the publication of the working document on the *Global Strategy to Reduce the Harmful Use of Alcohol*; our intention is to strengthen and focus this document and the eventual strategy.

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

- The harmful use of alcohol and per capita consumption of alcohol are conflated throughout the document, in apparent contradiction to the title and primary objective of the Strategy itself. The inclusion of 'per capita alcohol consumption' as a key indicator of success is and remains questionable. Such an approach would seem not to duly take into account societal, cultural or religious norms, which account for a higher consumption in certain regions (as outlined in the report). Furthermore, while certain regions may have seen slight decreases in the per capita consumption (i.e. Europe), the harmful consumption of alcohol has seen much greater declines – in fact, heavy-episodic drinking and alcohol-related mortality all declined at far greater rates than per capita alcohol consumption in Europe over the past number of



years¹. This shows the success of the previous Action Plan. By and large, European consumers are drinking better, while not necessarily drinking more. A correlation between per capita alcohol consumption and harmful alcohol consumption is further weakened when the comparative affluence or wealth of a society is considered; as stated in the report, wealthier regions consume more alcohol, but these regions are not necessarily those with the highest rates of *harmful* consumption of alcohol.

- The report notes that the Europe region “surpass[ed] the target set in the global monitoring framework for NCDs” in reducing the consumption of alcohol. The report later reports that, despite this, the WHO-Europe Region did not meet its target in reducing alcohol-related mortality or DALYs attributable to alcohol consumption. This discrepancy shows that targeted policies focused on harmful consumption of alcohol are required, instead of a broad policies aimed at reducing alcohol consumption per se, as this will not always have the desired knock-on effect.
- There are huge inherent geographical, economic and social discrepancies within the sizeable WHO-Europe Region (around 900 million people), especially with regards to the very different trends observed regarding per capita consumption and harmful alcohol consumption in different countries. In particular, countries in the Western area of the Region (the so-called EU+ Region) tend to show very different patterns than countries located in the rest of the WHO Europe Region. **The use of an overall per capita alcohol consumption target on a regional level for the entire WHO Europe Region as an indicator for success of the Global Strategy to Reduce the Harmful Use of Alcohol therefore seems methodologically undifferentiated and questionable and must be reconsidered and refined.**

The promotion of ‘one-size-fits-all’ policies such as the SAFER initiative package fails to take into account country-specific characteristics and may, in specific cases, be counter-productive

- Many Europeans may choose to drink alcohol as “the drinking of alcoholic beverages is strongly embedded in the social norms and cultural traditions of many societies” [“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”]. The pursuit of policies to discourage this consumer choice may have limited effects as a result. At the same time, policy approaches which aim to best inform and educate the consumer about this choice – how to drink

¹ Status report on alcohol consumption, harm and policy responses in 30 European countries 2019. Link: https://www.euro.who.int/_data/assets/pdf_file/0019/411418/Alcohol-consumption-harm-policy-responses-30-European-countries-2019.pdf



responsibility, the importance of moderation, the strong discouragement of risky behaviour – may prove ultimately to be a more effective and sustainable strategy. Certain SAFER policies may therefore not be particularly suitable for certain regions.

- In particular, the SAFER initiative contains certain policies which would seem unsuited to highly-regulated policy environments, such as in Europe (particularly in the so-called EU+ Region in the WHO Europe Region). In fact, their implementation could have counter-productive impacts, in particular on those who consume alcohol to a harmful or risky level. In Europe, increases in the price of alcohol, or reductions in the availability of alcohol, have been shown to disproportionately impact on moderate drinkers, but not those more likely to drink alcohol to a harmful level. However, risky drinkers may revert to alternative sources for alcohol. In Europe, increases in excise have often been accompanied by increases in parallel trade, spikes in the consumption of illicit or unrecorded alcohol, a consumer practice which is “associated with significant health risks and challenges for regulatory and law enforcement sectors of governments” in this report.
- The central claim behind calls for policies such as excise hikes is that reduced affordability of alcohol would in turn lead to reduced consumption of alcohol. However, in most of Europe, the opposite has been the case: alcohol has structurally become more affordable in recent decades (as societies have become more affluent) while the consumption per capita has steadily declined. A blunt instrument such as a tax increase on the price of alcohol might see an initial one-off effect, but is unlikely to have a long-term impact – especially in those European countries which are expected to continue to see the standard of living and wealth of society increase in the coming years. Policies which seek to inform and educate the consumer about the importance of responsible consumption of alcohol may therefore be regarded as a more suitable tool for high-income countries.
- There are a number of countries in Europe who have already introduced considerable structural barriers to the availability and affordability of alcohol. In line with this, the report’s suggestion that there have been “general trends towards deregulation in recent decades [which] resulted in a weakening of alcohol controls” is not accurate– there have already been a number of restrictions on sales, advertising and marketing introduced throughout the European region, combined with a number of self- and co-regulatory initiatives pursued by producers themselves. **The suitability of broad and sweeping recommendations for the implementation of the SAFER initiative policies should therefore be reconsidered.**



Proposals to exclude alcohol producers from policy dialogue and development of standards are not in line with recent WHO and UN positions and may be counter-productive, especially at this stage

- Somewhat surprisingly, this report notes that alcohol is not subject to a framework convention – in this context, it is essential to point out within the document that a proposal in this regard was explicitly not supported at the very World Health Assembly where the roadmap on this Global Strategy was agreed. To re-introduce or seek support for this idea again at this stage, especially within this Strategy, which was endorsed by Member States as the preferred way forward in tackling the harmful use of alcohol, would seem to go against the mandate given in the Executive Board decision EB146 (14). Furthermore, the report warns against the involvement of the private sector in policy dialogue and the development of policy. However, such wording is not aligned with the position endorsed in the UN High-Level Political Declaration on NCDs (2018) which explicitly “encourage[ed] economic operators in the area of alcohol production and trade, as appropriate, to contribute to reducing harmful use of alcohol in their core areas”²
- The report suggests that “the production of alcoholic beverages has become increasingly concentrated and globalized in recent decades, particularly in the beer and spirits sectors” (p.4). This is factually incorrect in the case of spirits given that, worldwide, the top 4 spirits producers together have an aggregate market share of merely 9%³. To speak of a high concentration in spirits production is therefore factually incorrect and must be amended.
- The marketing and advertising of alcohol is already highly regulated by consistently high standards across Europe. Alcohol marketing does not target adolescents – broad statements to the contrary as seen in the report should therefore be modified or removed. Our sector has worked extensively, also in dialogue with the WHO, to further evolve, refine and adapt standards for advertising and marketing so as to reduce the exposure of certain vulnerable groups (minors, problem drinkers) to alcohol advertising. For such efforts to be successful, a close, ongoing dialogue with the private sector and relevant stakeholders is fundamental – **therefore policy approaches that seek the exclusion of alcohol producers and other economic operators would be counter-productive in that regard, and need to be reconsidered.**

² Political declaration of the 3rd High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases <https://digitallibrary.un.org/record/1648984?ln=en>

³ “The Alcohol Industry”, Institute for Alcohol Studies, <http://www.ias.org.uk/uploads/pdf/Factsheets/FS%20Industry%2012018.pdf>



We would like to thank the WHO for their consideration of the points raised in this response, and remain available should further clarification be necessary.

Sri Lanka Alcohol Policy Alliance (SLAPA)

Country/Location: Sri Lanka

URL: madyasara prthipathi sandanaya - fb page

Submission

We, Sri Lanka Alcohol Policy Alliance (SLAPA) is an organization working for effective policy formulation of and ensuring effective implementation policies related to alcohol in Sri Lanka. Members of SLAPA include Healthy Lanka Alliance for Development (HLAD), Foundation for Innovative Social Development (FISD), Sri Lanka Temperance Organizations, Federation Of Non-Governmental Organization Against Drug Abuse (FONGOADA), Civil Society Alliance and many others Non-Governmental Organization working to prevent alcohol use and related problems in Sri Lanka. SLAPA closely works with FORUT International and Global Alcohol Policy Alliance in this connection. 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. SLAPA presents the following suggestions, views and perspectives to strengthen the action plan for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol as well as and to make it more relevant in the context of LMICs.

Need for Community Action and Preventive Education

SLAPA emphasizes the need for including community action, community empowerment and preventive education to as initiative along with WHO led SAFER indicatives and “best buys” as the Action area 3: Partnership, dialogue and coordination in for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol (page 13-16) and in Area 3. Community action, (Global Strategy to Reduce the Harmful Use of Alcohol. WHO, 2010). The alcohol expectancy challenge model could play a very important role in this connection. Civil Society Organizations could play an important role in mobilization for communities for reduction of alcohol use and related problems.

Initiative for reduction of alcohol use should not only focus on 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, but also the issues related to non-users of alcohol and the social environments.

The status quo of economic and political strengths the economic operator of alcohol vis-a-vie the governmental actors and non-governmental sector actors in the context of LMICs should be considered any policy dialogue with them for effective policy formulation on alcohol. The imbalance of power became evident when the economic operators were able continue as usual even during the period of Covid 19 in many 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 most 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 device 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 organizations (SAPROs) and Trade Groups will only further the poetries of the alcohol as an ordinary substance and its use as a global phenomenon for which fit for all solutions such “responsible drinking” is 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 delt 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 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.

The action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol should be important to implement the already developed National Policy on Alcohol Control of Sri Lanka which is attached here with for your more information.

Men are more vulnerable than women to initiate alcohol use and to develop severe problems related to alcohol use. Therefore challenging masculinities and femininities is and effective alcohol prevention and treatment tool, which could be added to as a strategy under Area 1 in the document. This point is elaborated in the second file attached herewith

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.

Attachment(s): 2

00431_65_national-policy-on-alcohol-control-sri-lanka.pdf

00431_66_alcohol-and-masculinity.pdf

STIVA (Stichting Verantwoorde Alcoholconsumptie)

Country/Location: Netherlands

URL: www.stiva.nl

Submission

- * we recognize that a lot of people enjoy a drink while drinking in moderation, but there is a group of people who drink irresponsibly
- * we welcome every effort that is focused on preventing excessive or otherwise irresponsible alcohol consumption
- * public private partnership is key to the positive developments in combatting problematic alcohol consumption in the Netherlands and could/should work in other countries as well
- * choose for what works, not 'one size fits all'

Attachment(s): 1

00309_01_input-stiva-nl.pdf

WHO Consultation on the Working document for development of an action plan to strengthen the implementation of the Global Alcohol Strategy

On STIVA

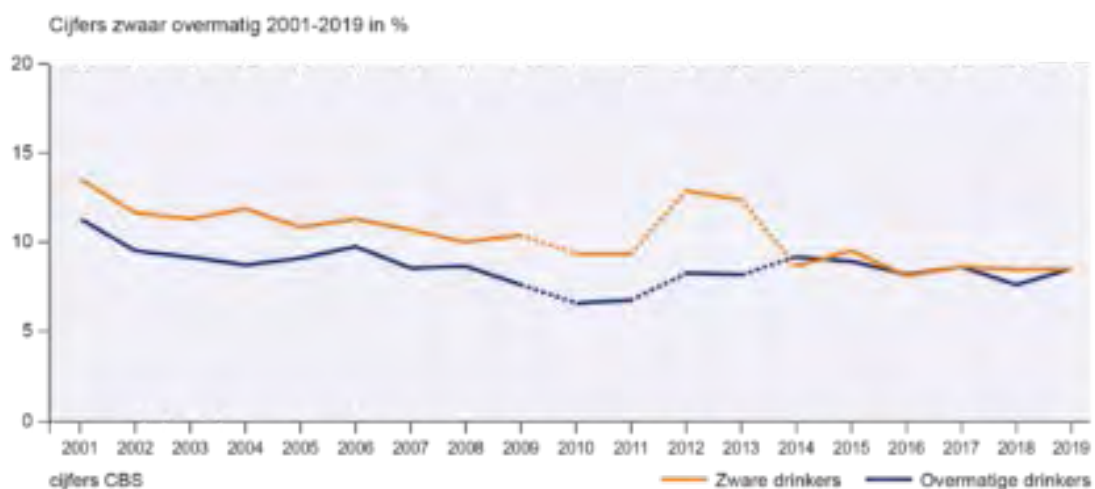
STIVA is the organization in the Netherlands which – on behalf of the beer-, wine- and spirits sector – works on the topic of responsible alcohol consumption.

We recognize that a lot of people drink in moderation, but there is still a number of people who drink irresponsibly. We consider any alcohol consumption by people under 18 as irresponsible and problematic alcohol consumption. As regards to drink driving we strongly believe that people that participate in traffic should not drink at all.

Facts & Figures

We're happy to say that In the last 10 to 15 years the development of responsible alcohol consumption has taken the right turn in the Netherlands.

The percentage of people who engage in heavy episodic drinking has dropped from 13,6% in 2001 to 8,5% in 2019.



The percentage of minors who engage in last month HED has halved from about 40% in 2005 to under 20% in 2019.



When we take a look at drink driving, the percentage of people who were found to have been drinking over the BAC alcohol limit at police road stops dropped from 4,0 to 1,4%

Tabel 2.1

Ontwikkeling bestuurders (in procenten) naar promillageklasse (2002-2017).

	2002	2006	2010	2011	2013	2015	2017
minder dan 0,2‰	91,4	93,0	94,2	94,6	95,0	95,1	96,1
0,2 tot 0,49‰	4,7	4,2	3,6	3,4	3,3	3,2	2,4
0,5 tot 0,79‰	2,2	1,5	1,1	1,0	1,0	0,9	0,8
0,8 tot 1,29‰	1,3	1,0	0,7	0,7	0,5	0,5	0,5
1,3‰ of meer	0,5	0,4	0,4	0,3	0,2	0,3	0,1
Overtreeders	4,0	2,9	2,2	2,0	1,7	1,7	1,4

Not 'one size fits all' but the freedom to choose what works best

These developments show that the approach in the Netherlands works. We fully understand that our approach is different from other countries. In some countries the developments might be successful as well albeit by undertaking different activities. Therefore, we would strongly recommend to keep as much as possible all policy options open and not narrow it down to promote one initiative or approach over the other. Our national context and the long history of promoting responsible alcohol consumption requires a different approach than the approach that works fine in other countries.

Inherent conflict?

The working document states that there is an inherent conflict between the interests of alcoholic drinks producers and the interests of public health. We don't agree with this opinion. In the Netherlands we cooperate since 2002 in the BOB campaign (drinkdrive). We do that in collaboration with the Dutch Traffic Department and the Dutch Road Safety Association. We don't consider it in our best interest when people who have drunk too much

get behind the wheel of their car. We want them, their families and friends, but other participants in traffic as well to return safely to their loved ones. That is our prime interest.

STIVA and other economic operators are member of the Dutch National Prevention Agreement. This is an official platform that is coordinated by government. In this partnership we work together with all other stakeholders to promote responsible alcohol consumption and reduce problematic alcohol consumption and its negative impact on individual as well as society.

So there is no inherent conflict and we seek to intensify the partnership that we have with government, NGO's and other members of the Dutch National Prevention Agreement initiative.

Final remark

We think it's important to strive to combat problematic alcohol use not alcohol consumption per se. Yes, there are situations and occasions that people should not drink at all. At work, when pregnant, when underage and when driving a car. Also, alcohol consumption is not a solution when you're stressed or to forget your worries.

But other than that, moderate alcohol consumption is something that can be enjoyable. Our aim is to focus on combatting alcohol abuse and misuse. We're doing that in a partnership with all kinds of organizations. We truly believe that the Global Alcohol Strategy can have an important role in supporting the multi stakeholder approach that is very effective in the Netherlands.

Stop Drink Network,

Country/Location: Thailand

URL: www.sdnthailand.com

Submission

Stop Drink Network (SDN)

110/287 Nawamin Road, Phokeaw Yek4, Bugkum, Bangkok 10240

Webside : www.sdnthailand.com

Email: tom_teera@hotmail.com , Tel +66 29483300 , +66 813483739

Manager : Theera Watchrapanee

Stop Drink Network Established in mid 2003, we are networking of peoples' organizations Engaged allies from civil society and a great variety of 264 partner organizations. Our strategies to change alcohol norm and social value in cultural events and to protect a new comer form big alcohol's marketing. We are works with various partners such as government and public institutions across the country. We are the membership of Movendi International and The Asia Pacific Alcohol Policy Alliance(APAPA).

We are grateful to comment the 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,

Action Area 1 IMPLEMENTATION OF HIGH-IMPACT STRATEGIES AND INTERVENTIONS

Add to Member states

- The Government to ensure that all equipment and maintenance for alcohol blood test are adequate for the local officer.

Action Area2 ADVOCACY, AWARENESS AND COMMITMENT

Advocacy awareness and commitment very important as soft power mission to aware the policy maker and people perception that mean Social Climate effected, to stimulated the best buy policy had worked.

Add to Global target: By 3 Year after Action plan started, The world no alcohol day accepted by the WHA.

Add to Member states

- The Government have the national alcohol awareness campaign by not only alcohol related harm to NCD but to harm to others too.
- limited and stop the campaign by any organization that get conflict of interest from alcohol industry for example the campaign to drink responsibility or drink wise , the alcohol quality and alcohol norm when drinking is normal behavior toward to adolescence people.

- To empowerment and supported the youth groups to monitor the alcohol marketing and advocate to the society. Youth voice would be the strong voice to shame the violation the law of alcohol industry

Add to the WHO secretariat

- To empathize the member states about the World no alcohol day in term of soft power to created the social climate
- To organize the alcohol conference as the obstacle to SDGs and alcohol norm by 3 conferences during this action plan, to share the knowledge of how to protect the SDG from alcohol marketing and negative effected , alcohol in term of norm, an advocacy and the commitment with the politicians ,the government and civil society.

Add and amendment to International partner and non state actor

- UNICEF and others Child Rights organization would be initiative to studies and commit the alcohol related harm to child rights and all quality of child life by received the alcohol problem in the policy and action plan and refuse to alcohol industry's sponsorship
- Amendment Action3 : Limited the economic operator role only feedback and response the marketing concern to the government and would be compliance the regulation.

Note : We worry about the text on the role of economic partner as below

...towards eliminating the marketing and advertising of alcoholic products to minors, refrain from promoting drinking, eliminate and prevent any 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 and contraindications for alcohol use).

That exactly paradox when the economic partner part of framing step in refrain from promoting drinking or co-regulatory framework about the labels of alcohol beverages. The economic would be propose the how to drink responsible or drink wise that proposal toward to young adolescence.

Action Area 3: PARTNERSHIP, DIALOGUE AND COORDINATION

Add to International partner and non state actor

- Government , NGOs and academia sector would coordinate and partnership, then support from WHO. The round up conference during 2 year for share the experience, share idea and empowerment to all members. In global level and regional level.

Action Area 4 : TECHNICAL SUPPORT AND CAPACITY-BUILDING

Add to Member state

- Youth group is the active citizen, wound be one of target of capacity building.

Attachment(s): 0

Systembolaget AB

Department/Unit: *Corporate, legal and public affairs*

Country/Location: Sweden

URL: www.omsystembolaget.se

Submission

SYSTEMBOLAGET'S COMMENTS ON THE WORKING DOCUMENT FOR DEVELOPMENT OF AN ACTION PLAN TO STRENGTHEN IMPLEMENTATION OF THE GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL.

As alcohol isn't an ordinary commodity, the retail sales of alcoholic beverages in Sweden is managed by a state-owned company – Systembolaget AB. Systembolaget's retail monopoly encompasses all alcoholic beverages above 2.25 percent ABV with a minor exception for beer up to 3.5 percent ABV. Systembolaget's purpose is to reduce alcohol related harm by limiting availability and remove private profit motives from the retail sale of alcohol.

Systembolaget has the following comments on the WHO action plan working paper set out above - hereinafter referred to as the "plan":

The plan is comprehensive and Systembolaget believe it will strengthen the implementation of the global alcohol strategy and help reduce alcohol related harm in our societies. It is positive that the public health perspective is emphasized as a key to successfully implementing the global alcohol strategy. Furthermore, the holistic approach to the harm and societal costs caused by alcohol broadens the perspective. This will assist in reducing the negative impact alcohol related harm may have on several of the UNSDG and further the overarching target of Agenda 2030 that no one should be left behind. This goal will, as is stressed in the plan, be facilitated by strengthening positive trends. For example, that young people in Europe drink less than previous generations – although it is important that we aren't "satisfied" but continue to work on this issue.

It is positive that the plan is based on the SAFER initiative and that it reiterates; the importance of restricting the availability of alcohol, actively using the price tool and implement restrictive rules for the marketing of alcohol. This is fully in line with the Swedish alcohol policy model - and Sweden may serve as an example in these areas. It is helpful that the WHO in the plan has given examples on how different actors, depending on their expertise and role, should contribute to fulfill the plan and that the WHO in this aspect has emphasized the key role played by public health actors.

Finally, it is good that the WHO highlights the importance of cooperation on issues related to reducing alcohol related harm as well as the importance of collecting data and statistics at a national level as these are key factors to successfully reduce alcohol related harm. Here, the WHO plays an important role in collecting and making such data widely available. In this context Systembolaget wish to underline the importance of research. The WHO has done a great job in building and sharing knowledge on how to efficiently reduce alcohol related harm. This work is of great importance and it would be beneficial if it could be strengthened in the coming years.

Systembolaget AB

Johan Lindblad

Head of public affairs

Attachment(s): 0

Tairawhiti Community FASD Working Group

Country/Location: New Zealand

Submission

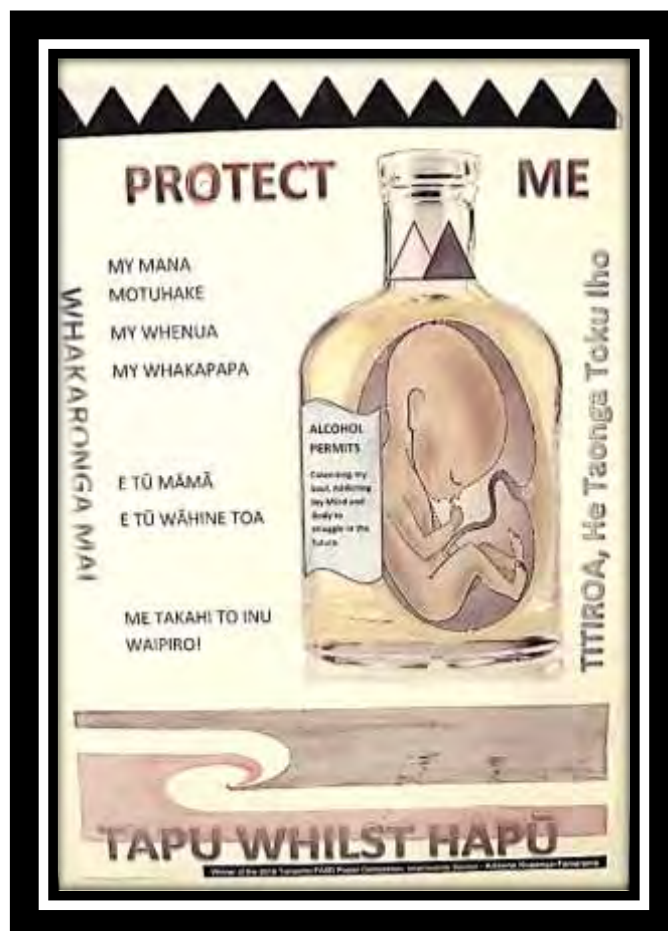
Tairawhiti Community FASD Working Group is an independent, voluntary group from the East Coast of Aotearoa New Zealand, promoting alcohol free pregnancies, raising awareness of Fetal Alcohol Spectrum Disorders, advocating for national alcohol harm reduction measures and the resourcing of assessment and support for individuals with FASD and their families. We run a FASD drop in centre, hosting education sessions for a range of professionals in our communities and workshops and support groups for whanau.

We wish to support all recommendations outlined in the submission presented by Alcohol Healthwatch. We also want to draw your attention again specifically to the following section, as we believe that these recommendations, if enacted, will make a measurable difference in both prevention and intervention outcomes, including improving access to appropriate diagnostic services and supports.

Preventing and reducing inequities in FASD

Attachment(s): 1

00296_62_submission-to-the-world-health-organization-tairawhiti-fasd-group.pdf



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'

11 December 2020

Tairawhiti Community FASD Working Group

Tairawhiti Community FASD Working Group is an independent, voluntary group from the East Coast of Aotearoa New Zealand, promoting alcohol free pregnancies, raising awareness of Fetal Alcohol Spectrum Disorders, advocating for national alcohol harm reduction measures and the resourcing of assessment and support for individuals with FASD and their families. We run a FASD drop in centre, hosting education sessions for a range of professionals in our communities and workshops and support groups for whanau. 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 please contact:

Courtney Stubbins

Tairawhiti Community FASD Working Group

P: (027) 4056592

E: courtney.stubbins@turangahealth.co.nz

We wish to support all recommendations outlined in the submission presented by Alcohol Healthwatch. We also want to draw your attention again specifically to the following section, as we believe that these recommendations, if enacted, will make a measurable difference in both prevention and intervention outcomes, including improving access to appropriate diagnostic services and supports.

Preventing and reducing inequities in FASD

1. 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.
2. 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
3. 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.

4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.

Tanzania Network Against Alcohol Abuse - TAAnet

Country/Location: United Republic of Tanzania

URL: taanet.org

Submission

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

Tanzania Network Against Alcohol Abuse (TAAnet) is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

TAAnet is a network that works towards the improvement of public health and social economic status of Tanzania population through reduction of alcohol abuse.

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 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

00473_07_taanet-logo.pdf

Teesside University, INEBRIA

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

URL: <https://research.tees.ac.uk/en/persons/dorothy-newbury-birch>

Submission

Colleagues from INEBRIA were was invited to join the Alcohol and Drugs Forum organized twice by WHO. We believe that it is important to support that initiative. We at INEBRIA are committed in helping WHO to disseminate/research/build capacity on health and public health responses to alcohol problems at an international level.

We believe that it is imperative to avoid the interference of the economic operators in policy making and specifically in SBI.

Attachment(s): 0

Texans for Safe and Drug-Free Youth

Country/Location: United States of America

URL: txsdy.org

Submission

Texans for Safe and Drug Free Youth (TXSDY) is grateful to the World Health Organization for developing the Action Plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. We are pleased to submit our recommendations to further improve this document. Overall, we recommend that the actions and targets should be made as specific and operationalized as possible, with concrete and measurable targets that are reviewed by the Director General in a biennial report on the progress of the plan.

Additionally, we encourage the limitation of involvement by those with commercial interests in alcohol, and when these entities are engaged in this process, we recommend complete transparency of their engagement. Moreover, our organization engages civil society at national, state, and community levels and strongly believes it is important for this action plan to include ways in which these efforts are funded and implemented.

Attached are our suggestions and feedback by each section of the working document.

Attachment(s): 1

00476_08_txsdy-who-response-20201213.pdf



Response to the World Health Organization's Action Plan to Strengthen the Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Texans for Safe and Drug Free Youth (TXSDY) is grateful to the World Health Organization for developing the Action Plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. We are pleased to submit our recommendations to further improve this document. Overall, we recommend that the actions and targets should be made as specific and operationalized as possible, with concrete and measurable targets that are reviewed by the Director General in a biennial report on the progress of the plan.

Additionally, we encourage the limitation of involvement by those with commercial interests in alcohol, and when these entities are engaged in this process, we recommend complete transparency of their engagement. Moreover, our organization engages civil society at national, state, and community levels and strongly believes it is important for this action plan to include ways in which these efforts are funded and implemented.

Below we provide our suggestions and feedback by each section of the working document.

SETTING THE SCENE

1. **Working Document (Box 1 – Aims):** “to give guidance for actions at all levels; to set priority areas for global action”
 - a. **TXSDY Response:** We agree that it is important for there to be comprehensive and coordinated global action to reduce the harms associated with alcohol use. The need for an international framework on alcohol use should be made more explicit throughout this document, including in many of the Operational Objectives of the Action Plan as well as the Key Areas for Global Action. We believe this should also include specific strategies and/or actions that civil society can implement.
2. **Working Document Sentence (pg. 3):** “Overall – despite some decreasing trends in alcohol consumption in some segments of the population, improvements in some indicators of the disease burden attributable to alcohol consumption, and alcohol policy developments at the national level – the implementation of the Global Strategy has not resulted in considerable reductions in alcohol-related morbidity and mortality and the ensuing social consequences.”
 - a. **TXSDY Response:** Providing more specific trends and implementation data on the high and low performing states would allow advocates to be more informed and present concrete data to their lawmakers. We also recommend that the working document specifically refer to the lack of resources at the region/country level as a driving factor for low implementation. Additionally, we would recommend that the document consider challenges facing civil society with respect to lack of resources and implementation of prevention strategies.

3. **Working Document Sentence (pg. 4):** "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.
 - a. **TXSDY Response:** WHO should explicitly recognize the need for a binding international framework on alcohol control, similar to the WHO Framework Convention on Tobacco Control.
4. **Working Document (pg. 5):** "Limited technical capacity, human resources and funding hinder efforts in developing, implementing, enforcing and monitoring effective alcohol control interventions at all levels."
 - a. **TXSDY Response:** We support this observation and recommend that WHO more explicitly call for Member States to dedicate more funding for alcohol prevention and policy research, including resources to engage citizen stakeholders.
5. **Working Document (pg. 5):** Page 5 does a nice job of detailing many of the statistics on morbidity and mortality associated with alcohol use.
 - a. **TXSDY Response:** The scientific link between alcohol and cancer is strong, and we believe this association should be specifically mentioned in this background section to draw further attention to it.

GOAL OF THE ACTION PLAN

1. **Working Document (pg. 7):** "Effective implementation of the action plan at regional levels may require development or elaboration and adaptation of region-specific action plans."
 - a. **TXSDY Response:** The need for regional action plans is critical and should be reflected more strongly. We recommend replacing "may" with "will" in the identified sentence, so it reads "Effective implementation of the action plan at regional levels will require development of elaboration and adaptation of region-specific action plans."

PROPOSED OPERATIONAL OBJECTIVES FOR THE ACTION PLAN, GUIDING PRINCIPLES AND KEY AREAS FOR GLOBAL ACTION

1. **Working Document (pg. 9):** Operational Objectives of the Action Plan
 - a. **TXSDY Response:** Across each of the operational objectives, concrete accountability measures should be included to measure progress against these objectives.
2. **Working Document (pg. 10 – Principle 2):** "Policies should be equitable and sensitive to national, religious and cultural contexts."
 - a. **TXSDY Response:** We agree that this is a very point, and recommend that the document specifically refer to an equity-based approach to alcohol control.
3. **Working Document (pg. 10 – Principle 4):** "Public health should be given proper deference in relation to competing interests and approaches that support that direction should be promoted."

- a. **TXSDY Response:** We again applaud the WHO for including this important principle, but believe this statement should be stronger and explicitly protect all components of the Action Plan from commercial interests.

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

1. **Working Document (pg. 12 – Action 2 for Member States):** 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.
 - a. **TXSDY Response:** We support this important action and encourage the WHO to ensure no commercial interest involvement in this process.
2. **Working Document (pg. 12- Action 2 for WHO Secretariat):** “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.”
 - a. **TXSDY Response:** We recommend a more specific time frame for review of the evidence than “periodically” (e.g., every five years).
3. **Working Document (pg. 12- Action 3 for WHO Secretariat):** “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.”
 - a. **TXSDY Response:** This should be taken as an opportunity to explicitly call for the development of a binding international framework on alcohol control.
4. **Working Document (pg. 12- Action 3 for Non-State Actors):** “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.”
 - a. **TXSDY Response:** It should be made clear that economic operators should not be funding research, given the industry’s emphasis on funding studies that support their claim of “responsible drinking”. We encourage this action instead to recommend that civil society and academia not engage in formal or informal partnerships with economic operators or to accept funding from economic operators.

ACTION AREA 2: ADVOCACY, AWARENESS AND COMMITMENT

1. **Working Document (pg. 14 – Action 6 for Member States):** “Increase awareness of the health risks of alcohol use and related overall impact on health and wellbeing 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.”
 - a. **TXSDY Response:** We support the need for member states to increase awareness of the health, safety, and equity risks associated with alcohol use, as well as countering misinformation largely disseminated by commercial interests. However, we believe that

a national awareness day should be revised to an alcohol awareness week that is directly tied to concurrent policy efforts, given the limited evidence of effectiveness of awareness and education campaigns operating in isolation from a broader approach.

2. **Working Document (pg. 14 – Action 4 for WHO Secretariat):** “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.”
 - a. **TXSDY Response:** Global Status reports on alcohol should be prepared and disseminated more frequently to check progress against the goals set forth in this action plan. Tobacco status reports are released every two years, and we recommend alcohol reports be prepared on the same schedule.
3. **Working Document (pg. 14 – 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.”
 - a. **TXSDY Response:** We support the need to discuss trade and investment agreements, but do not understand the explicit action described here. We recommend additional clarity.
4. **Working Document (pg. 14 – Action 2 for Non-State Actors):** “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 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.”
 - a. **TXSDY Response:** The sole responsibility for monitoring and reporting commercial interest involvement in alcohol research and reduction efforts cannot be on non-state actors. The WHO Secretariat has an important role to play here, and an action that specifies this role should be added under this Action Area.
5. **Working Document (pg. 14 – Action 3 for Non-State Actors):** “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 from promoting drinking, eliminate and prevent any 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 and contraindications for alcohol use).”
 - a. **TXSDY Response:** It should be made clear that economic operators should not be funding research, given the industry’s emphasis on funding studies that support their claim of “responsible drinking”. We encourage this action instead to recommend that civil society and academia not engage in formal or informal partnerships with economic operators or to accept funding from economic operators.

ACTION AREA 3: PARTNERSHIP, DIALOGUE AND COORDINATION

1. **Working Document (pg. 16 – Action 2 for Non-State Actors):** “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.”
 - a. **TXSDY Response:** The sole responsibility for monitoring and reporting commercial interest involvement in alcohol research and reduction efforts cannot be on non-state actors. The WHO Secretariat has an important role to play here, and an action that specifies this role should be added under this Action Area.
2. **Working Document (pg. 16 – Action 3 for Non-State Actors):** “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.”
 - a. **TXSDY Response:** We agree and support this action, but we believe it should be rewritten to say “shall refrain from engaging in and/or interfering with” alcohol policy development and evaluation.
3. **Working Document (pg. 16 – Action 6 for WHO Secretariat):** “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.”
 - a. **TXSDY Response:** We recommend high levels of transparency around this process, including the publication of agendas in advance of the dialogues and meeting notes within one month of the dialogues.

ACTION AREA 4: TECHNICAL SUPPORT AND CAPACITY-BUILDING

1. **Working Document (pg. 18 – Action 7 for Non-State Actors):** “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.”
 - a. **TXSDY Response:** We support the recommendations for monitoring and reporting, but recommend a broader mandate be provided by revising to “and provide recommendations on the way forward.” (i.e., removing “to strengthen the implementation of the Global Strategy”)

ACTION AREA 6: RESOURCE MOBILIZATION

- 1. Working Document (pg. 22 – Action 1 for Non-State Actors):** “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.”
 - a. **TXSDY Response:** We support this important action and encourage UN agencies to remain independent of alcohol industry funding. We know that many transnational alcohol companies have provided funding to UN agencies in the past through corporate social responsibility initiatives. The need for this independence should be clearly highlighted
- 2. Working Document (pg. 22 – Action 3 for Non-State Actors):** “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.”
 - a. **TXSDY Response:** It should be made clear that economic operators should not be funding research, given the industry’s emphasis on funding studies that support their claim of “responsible drinking”. We encourage this action instead to recommend that civil society and academia not engage in formal or informal partnerships with economic operators or to accept funding from economic operators.

Texans for Safe and Drug-Free Youth (TxSDY) is the state’s leading organization working to end underage alcohol, tobacco, and other drug use. Founded in 1997, with funding from the Robert Wood Johnson Foundation administered by the American Medical Association, the statewide coalition builds on the strengths and successes of its longtime identity, Texans Standing Tall, while bringing new focus and energy to its mission of creating healthier and safer communities.

Thai Health Promotion Foundation

Department/Unit: *Partnership and International Relations Section*

Country/Location: Thailand

URL: <https://en.thaihealth.or.th/>

Submission

We truly appreciate the secretariat for drafting the comprehensive action plan. We concur with most action areas, targets, and proposed actions. We have a few suggestions to strengthen the Action Area 6. Resource Mobilization, as follows:

1st Suggestion: For clarity, we would like to request the secretariat to define a clear numerical Global target 6.2 (the increase in the number of countries with earmarked funding), which could be a percentage increase of the baseline number, the actual increase in the number of countries, or any other way to clearly quantify such targeted increase.

2nd Suggestion: we would like to propose an additional "Action for the Secretariat" to support the Member States in advocating for earmarked funding from alcohol tax revenues, noting that without IGOs' "strong convincing voice" to support earmarked funding policy, most member states may face domestic challenges especially from the government's financial authorities (e.g. Ministry of Finance), and target 6.2 to increase the number of countries with such earmarked funding may be difficult to achieve. Thus, we propose an additional "Action for the Secretariat" as follows:

- "Provide the policy guidance, advocacy and, as required, technical assistance to member states for 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 conditions, in liaison and cooperation with the World Bank Group and other major partners in the United Nations system."

3rd Suggestion: To make it clear that economic operators should be refrain from all funding of public health and policy-research on alcohol, we propose the addition of the word "and indirect" in the Action 3. for the international partners and non-State actors. The revised version now should read:

Action 3. "Economic operators ..., and to refrain from direct and 'indirect funding' of public health and policy-related research ..."

Attachment(s): 0

The Alcohol and Families Alliance

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

URL: <https://www.alcoholandfamiliesalliance.org/>

Submission

The Alcohol and Families Alliance (AFA) is an alliance of UK-based organisations from across the voluntary and statutory sectors united in reducing the harms experienced by families as a result of alcohol.

It is estimated there are 595,000 adults with alcohol dependence in England and 189,119 children living with at least one alcohol dependent adult. It is common for these children to experience neglect, physical and emotional abuse. Many develop both mental health and their own substance use problems as a result of their experiences, in turn increasing the likelihood of negative outcomes as they grow older. Adult family members are also affected by a loved one's drinking, including through financial problems, relationship issues, mental ill health, bereavement, and domestic abuse.

AFA welcomes proposed action 4.4 for Member States, which includes supporting mutual help groups and associations of affected individuals and their families. However, given 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, we believe further action is required in the Action Plan to include and recognise the importance of supporting families affected by alcohol use.

Attachment(s): 1

00367_32_who-consultation-on-developing-a-global-alcohol-action-plan-alcohol-and-families-alliance-response-11.12.2020.pdf



Alcohol and Families Alliance
120 Cromer Street
London, United Kingdom WC1H 8BS
info@alcoholandfamiliesalliance.org

11 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 Alcohol and Families Alliance (AFA) is an alliance of UK-based organisations from across the voluntary and statutory sectors united in reducing the harms experienced by families as a result of alcohol. The AFA believes that:

- Current policy does not sufficiently protect children and families from alcohol-related harms
- The misuse of alcohol can have serious, and detrimental, effects on the health and wellbeing of children and families
- The negative effects of alcohol on children and families are not confined to those incurred by drinkers who drink at hazardous, harmful or dependant levels
- We should encourage an open conversation about alcohol and its effects on families, that challenges stigma and stereotypes
- Families deserve help and support to understand the potential impact of alcohol on their family and relationships

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.

Many of the AFA's member organisations have seen first-hand the harms alcohol dependency poses to children and families. The Adult Psychiatric Morbidity Survey (APMS) in 2014 estimated that there

are 595,000 adults with alcohol dependence in England and 189,119 children living with at least one alcohol dependent adult. It is common for these children to experience neglect, physical and emotional abuse. Many develop both mental health and their own substance use problems as a result of their experiences, in turn increasing the likelihood of negative outcomes as they grow older. Adult family members are also affected by a loved one's drinking, including through financial problems, relationship issues, mental ill health, bereavement, and domestic abuse.

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.

Furthermore, the AFA welcomes 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, given 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*, we believe further action is required in the Action Plan to include and recognise the importance of supporting families affected by alcohol use.

In addition, the Action Plan should include reference to the impact of drinking alcohol during pregnancy and provision of support to prevent and manage foetal alcohol spectrum disorders (FASD). A recent study which estimated national, regional, and global prevalence of alcohol use during pregnancy (Popova S., Lange S., Probst C., Gmel G. & Rehm J., 2017) estimated that 41% of pregnant women in the UK drink during pregnancy. Greater attention is required on this issue where prevention, information and support for those affected by FASD is currently lacking.

Thank you for your consideration.

Yours sincerely,

Vivienne Evans OBE, Chief Executive - Adfam
(Responding on behalf of the Alcohol and Families Alliance)

Adfam is a member organisation of, and provides the secretariat for, the Alcohol and Families Alliance

The Brewers of Europe

Country/Location: Belgium

URL: www.brewersofeurope.org

Submission

THE BREWERS OF EUROPE

Based in Brussels, The Brewers of Europe brings together national brewers' associations from 29 European countries and provides a voice to support the united interests of Europe's 10,000+ breweries. The Brewers of Europe promotes the positive role played by beer and the brewing sector in Europe and advocates the creation of the right conditions to allow brewers to continue to freely, cost-effectively and responsibly brew and market beer.

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.
- 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.

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 "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."

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 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 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.

- 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.

Attachment(s): 1

00225_36_the-brewers-of-europe-comments-07.12.2020-who-consultation-alcohol-plan-working-document.pdf



WHO working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

The Brewers of Europe's comments and suggestions for consideration

7 December 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:"

The Brewers of Europe

Based in Brussels, The Brewers of Europe brings together national brewers' associations from 29 European countries and provides a voice to support the united interests of Europe's 10,000+ breweries. The Brewers of Europe promotes the positive role played by beer and the brewing sector in Europe and advocates the creation of the right conditions to allow brewers to continue to freely, cost-effectively and responsibly brew and market beer.

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:

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- 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.
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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:

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- 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.
 - o 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.
 - o 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.
 - o Reflecting on the potential of the brewers' ability to reduce alcohol content without changing the quality of beer, [Professor 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."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:

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- 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.
- 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.

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.](#)

The Cancer Society of New Zealand

Country/Location: New Zealand

URL: <https://auckland-northland.cancernz.org.nz/>

Submission

Cancer is the single biggest cause of death in New Zealand and accounts for nearly a third of all deaths. More than 30% of cancers are potentially avoidable. Alcohol has been classified as a Group 1 carcinogen by the World Health Organisation's International Agency for Research on Cancer. The risk of cancer increases with the level of consumption of alcohol.

We support the strategy as:

1. Having an action plan for the Global Strategy to Reduce Harmful Use of Alcohol will support cancer charities to be part of the comprehensive civil society and government led action that is needed to reduce alcohol consumption, cancer risk and other alcohol-attributable harms.
2. Tobacco is the leading preventable cause of cancer in New Zealand and CSNZ has a key focus on advocacy for tobacco control policy as well as advocating for 'best buys' in relation to alcohol policies. Without the Framework Convention on Tobacco Control (FCTC) our ability to limit the industry's influence on policy would be greatly reduced. A similarly binding Framework Convention on Alcohol is urgently needed to reduce the continuing aggressive industry marketing and lobbying which have contributed to almost half the alcohol consumed in New Zealand being drunk in heavy drinking occasions.
3. The affordability, accessibility and industry marketing of alcohol in Aotearoa (NZ), especially in higher deprivation communities has resulted in disparities in alcohol related harm between Maori and non-Maori. A stronger equity focus is needed in the document, especially to protect indigenous people and the lower income communities and countries.
4. Support and resources from WHO are also needed in LMICs to enable government and civil society representatives to take action for effective alcohol policy. WHO Alcohol and Drug Unit needs to be better resourced to be able to offer this support and practical assistance to LMICs.

The Cancer Society New Zealand is pleased to see the 'best buys'/SAFER framework reflected in the document, however we suggest this needs greater emphasis, especially in the key areas for global action.

WHO needs to strongly encourage and support countries to implement the five science-based interventions laid out in the SAFER guidance.

- Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship and promotion
- Raising prices on alcohol through excise taxes and pricing policies
- Strengthening restrictions on alcohol availability
- Advancing and enforcing drink driving counter measures

- Facilitating access to screening, brief interventions, and treatment.
-

The monitoring indicators should include specific metrics of SAFER implementation, and countries' reporting on the implementation of SAFER policies should be supported, especially in LMICs.

Given the alcohol industries' inherent conflicts of interest and strenuous efforts to undermine effective alcohol policies globally, Cancer Society New Zealand does not support alcohol industry entities being listed as stakeholders with equal standing alongside civil society and other UN organisations. We strongly recommend this is changed in the document.

Attachment(s): 1

00300_64_who-submission-on-working-document-for-global-strategy-2020-id-32671.pdf



Submission to WHO from Cancer Society New Zealand on the Working Document for Development of an Action Plan for the Global Strategy to Reduce Harmful Use of Alcohol

The Cancer Society of New Zealand (CSNZ) is a non-profit organisation that is committed to reducing the incidence and impact of cancer in the community and reducing cancer inequities. We work across the cancer continuum with a focus on prevention, supportive care, provision of information and resources, and funding of research.

Cancer is the single biggest cause of death in New Zealand and accounts for nearly a third of all deaths.ⁱ More than 30% of cancers are potentially avoidable.ⁱⁱ Alcohol has been classified as a Group 1 carcinogen by the World Health Organisation's International Agency for Research on Cancer.ⁱⁱⁱ The risk of cancer increases with the level of consumption of alcohol.

Alcohol consumption has been estimated to be responsible for around 240 cancer deaths each year in New Zealand.^{iv} As well as impacts on health, alcohol use also has a huge economic impact including lost productivity and costs to the justice and health systems.

Inequities in harm reflect differences in access to living conditions and opportunities (adequate income, housing, employment), structural and institutional discrimination and differing neighbourhood environments. For example, there are more alcohol outlets in low income neighbourhoods leading to increased competition and availability of cheap alcohol which drives increased consumption and harm^v.

NZ research shows young Māori are five times more exposed to alcohol marketing and Pacific youth three times more exposed, than European youth^{vi}.

The strong association between exposure to alcohol marketing, heavier drinking and earlier onset of drinking results in young Māori and Pacific men aged 15-24 years suffering more harm from living in areas with high numbers of liquor outlets, compared to European men living in communities with the same number of liquor outlets.

Reducing alcohol consumption is an important and under-emphasised strategy to reduce cancer risk, cancer inequities and other harms. Policies that reduce the affordability (excise tax increases and minimum price), and restrict availability and marketing of alcohol are the most effective and cost-effective strategies for reducing alcohol consumption.^{vii}

Overarching comments on the draft strategy

We support the strategy as:

1. Having an action plan for the Global Strategy to Reduce Harmful Use of Alcohol will support cancer charities to be part of the comprehensive civil society and government led action that is needed to reduce alcohol consumption, cancer risk and other alcohol-attributable harms.
2. Tobacco is the leading preventable cause of cancer in New Zealand and CSNZ has a key focus on advocacy for tobacco control policy as well as advocating for 'best buys' in relation to alcohol policies. Without the Framework Convention on Tobacco Control (FCTC) our ability to limit the industry's influence on policy would be greatly reduced. A similarly binding Framework Convention on Alcohol is

urgently needed to reduce the continuing aggressive industry marketing and lobbying which have contributed to almost half the alcohol consumed in New Zealand being drunk in heavy drinking occasions.

3. The affordability, accessibility and industry marketing of alcohol in Aotearoa (NZ), especially in higher deprivation communities has resulted in disparities in alcohol related harm between Maori and non-Maori. A stronger equity focus is needed in the document, especially to protect indigenous people and the lower income communities and countries.
4. Support and resources from WHO are also needed in LMICs to enable government and civil society representatives to take action for effective alcohol policy. WHO Alcohol and Drug Unit needs to be better resourced to be able to offer this support and practical assistance to LMICs.

The Cancer Society New Zealand is pleased to see the 'best buys'/SAFER framework reflected in the document, **however we suggest this needs greater emphasis**, especially in the key areas for global action.

WHO needs to strongly encourage and support countries to implement the five science-based interventions laid out in the SAFER guidance.

- Enforcing bans or comprehensive restrictions on alcohol advertising sponsorship and promotion
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- Advancing and enforcing drink driving counter measures
- Facilitating access to screening, brief interventions, and treatment.
-

The monitoring indicators should include specific metrics of SAFER implementation, and countries' reporting on the implementation of SAFER policies should be supported, especially in LMICs.

Given the alcohol industries' inherent conflicts of interest and strenuous efforts to undermine effective alcohol policies globally, Cancer Society New Zealand does not support alcohol industry entities being listed as stakeholders with equal standing alongside civil society and other UN organisations. **We strongly recommend this is changed in the document.**

CSNZ would appreciate acknowledgement of the many cultures and communities where alcohol is not normalised and the role of the economic operators in undermining non drinking cultures with aggressive marketing strategies by transnational corporations.

Civil society organisations have a key role in monitoring commercial interests' interference with public health policy. However we need to be strongly supported by WHO and recommend the Secretariat has a key role in monitoring and countering this industry interference.

The World Cancer Research Fund has estimated cancer incidence will increase by 50% over the next decade. This has the potential to overburden health systems even in high income countries. We recommend the Working Document is strengthened as suggested above, so that alcohol attributable cancers can be reduced.

ⁱ Ministry of Health. Mortality 2016: data tables (provisional) Ministry of Health 2018. (cited 2019) Available from: <https://www.health.govt.nz/publication/mortality-2016-data-tables-provisional>

ⁱⁱ World Health Organisation. Retrieved October 2018 from: <http://www.who.int/cancer/prevention/en/>

ⁱⁱⁱ International Agency for Research on Cancer. Alcohol drinking Lyon: IARC, 1988.

^{iv} Connor J, Kydd R, MacLennan B, Shield K, Rehm J. Alcohol-attributable cancer deaths under 80 years of age in New Zealand. Drug and alcohol review. 2016 DOI: 10.1111/dar.12443.

^v Alcohol Healthwatch website <http://www.ahw.org.nz/Issues-Resources/Harm-to-M%C4%81ori>

^{vi} 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 [Tim Chambers, James Stanley, Louise Signal, Amber L Pearson, Moira Smith, Michelle Barr, Cliona Ni Mhurchu](#) *Alcohol*

and Alcoholism, Volume 53, Issue 5, September 2018, Pages 626–633, <https://doi.org/10.1093/alcalc/agy053>
20 July 2018

^{vii} Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., ... & Homel, R. (2010). Alcohol: no ordinary commodity: research and public policy. *Rev Bras Psiquiatr*, 26(4), 280-3.

The Government of the Hong Kong Special Administrative Region

Department/Unit: *Non-communicable Disease Branch*

Country/Location: China

URL: <http://www.change4health.gov.hk/>

Submission

Developing a Global action plan to reduce the harmful use of alcohol

The Department of Health, Hong Kong SAR, China Comments on the working document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

In response to the World Health Organization (WHO)'s 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, we read the documents and have the following comments and suggestions for consideration.

1. Reducing alcohol-related harm has been accorded primary importance in the prevention and control of non-communicable diseases ("NCD") in Hong Kong. In May 2018, the Government of Hong Kong Special Administrative Region of China (the HKSARG), on the advice of the high-level Steering Committee on Prevention and Control of NCD in Hong Kong ("the Steering Committee"), issued "Towards 2025: Strategy and Action Plan to Prevent and Control NCD in Hong Kong ("SAP)". A local target has been set out in the SAP that at least 10% relative reduction in the prevalence of binge drinking and harmful use of alcohol (harmful drinking/alcohol dependence) among adults and in the prevalence of drinking among youth by 2025. Being the Secretariat of the Steering Committee, the Department of Health (DH), of the HKSARG welcomes the World Health Organization (WHO)'s initiative to develop an action plan to strengthen implementation of the Global strategy to reduce the harmful use of alcohol. We appreciate that the draft action plan has clear delineation of the proposed actions for different stakeholders i.e. Member States, WHO Secretariat, international partners and non-State actors in six areas that provide more directions for each party.

2. As WHO rightly points out, competing interests across the whole of government, 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. In the absence of robust public health advocacy, the economic merits to society proposed by the alcohol industry in lobbying for their interests could have influence on policy decision of the government. To facilitate health ministries for advocacy role, the WHO may consider to set out in the working document more concrete actions and messages targeting at the non-health ministries of the government, so as to build and support broad intra-governmental mechanism for formulating and implementation of alcohol policy in the domain of public health and to facilitate the adoption of "whole-of-government" approach in health protection. This issue may be included as one of the actions for the WHO Secretariat in Action Area 4 regarding technical support and capacity-building.

3. DH is committed to achieving the SAP target of reducing alcohol-related harm for prevention and control of NCD. We will continue to work with relevant stakeholders and partners in both health and non-health sectors, locally and internationally, within and outside the government and will also take reference from the final version of the action plan to formulate actions and strategies in future, to protect people in Hong Kong from alcohol related harm.

The National Organisation for FASD (UK)

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

URL: www.nationalfasd.org.uk

Submission

Key points (please see attached full submission):

1. In its consultation, the WHO asks organisations to reply to the following statement: "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."
2. The National Organisation for FASD's response: The WHO draft action plan on alcohol harm dangerously omits prenatal alcohol harm. Reducing rates of alcohol exposed pregnancies and thus the incidence of Foetal Alcohol Spectrum Disorders (FASD) needs to be interwoven throughout the document and incorporated into the vision, goals and expected outcomes as does increased support for those living with FASD and their families. No so-called "Global Strategy to Reduce the Harmful Use of Alcohol" can be complete or credible without proper attention given to this key public health issue, recognised as one of the "leading causes of developmental disabilities worldwide" .
3. Recommendations: The WHO Global Strategy Action Plan should include measurable actions on increasing awareness of the risks of alcohol in pregnancy, decreasing incidence of FASD and increasing support for those with FASD:
 - a. All countries should have guidance about avoiding alcohol in pregnancy.
 - b. All countries should provide for education on the risks of alcohol in pregnancy.
 - c. All countries should have legislation requiring the labelling of alcohol products to reflect the risk of alcohol exposure in utero.
 - d. All countries should be encouraged to support legislation mandating signs warning of the dangers of alcohol in pregnancy at the point of sale (similar to Sandy's law in Ontario).
 - e. All countries should demonstrate progress to improve diagnosis, assessment and support for those with FASD.
 - f. The WHO should urgently convene a stakeholder meeting with individuals with FASD and their families/support people.
 - g. The WHO should acknowledge the 9th of September as International FASD Awareness Day (the 9th day of the 9th month highlighting the importance of abstaining for the 9 months of pregnancy) and encourage all countries to use this a key day for increasing awareness of the importance of avoiding the harms caused by prenatal alcohol exposure.

Attachment(s): 1

**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**

**from The National Organisation for FASD (UK)ⁱ
Submitted 13 December 2020**



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4. The World Health Organisation has a leading role in raising awareness and promoting best practice on public health issues. A focus on alcohol harm is welcome.
5. However, the current draft document dangerously omits one of the key alcohol harms – the lifelong effect alcohol has on a developing fetus or embryo through alcohol-exposed pregnancies.
6. The WHO vision is “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.” This is never going to be achieved if the harm caused by prenatal alcohol exposure is ignored. As the WHO states in the consultation document (p. 4), “limited levels of political will and leadership at the highest levels of governments” is holding back progress. This would also be true of the WHO if it fails to revise its current document and include harms caused by prenatal alcohol exposure. There simply is no excuse for this omission four decades after the first FASD diagnoses.
7. A WHO document (2016)^{iv} recognized that “The lifelong disabilities caused by exposure to alcohol in pregnancy (known as fetal alcohol spectrum disorders), together with other negative effects of exposure to alcohol on the pregnancy, are an important public health concern.”
8. The omission of prenatal alcohol harm and FASD in the current document goes counter to the latest scientific advice. For example, a recent editorial in the BMJ (December 2020) stated, “Evidence suggests three periods of dynamic brain changes that may be particularly sensitive to the neurotoxic effects of alcohol: gestation (from conception to birth), later adolescence (15-19 years), and older adulthood (over 65 years). Highly prevalent patterns of alcohol use may cause harm during these sensitive periods, including low level prenatal alcohol exposure, adolescent binge drinking, and low-to-moderate alcohol use in older adulthood. Although these patterns of alcohol exposure may be associated with less harm to individuals than sustained heavy drinking, the overall burden of harm in populations is likely to be large.”^v
9. Leading UK medical professionals and scientists have long promoted greater attention to these issues. As Professor Sir Al Aynsley-Green Kt wrote in the British Medical Association publication on “Alcohol in Pregnancy,” “The effects of alcohol during pregnancy should be everybody’s business.”^{vi}
10. According to the BMA: “The fetus is totally unprotected from alcohol circulating in the blood system.” BMA (2016) What more devastating alcohol harm can there be than lifelong organic brain damage and other harm caused to developing systems before an individual draws their first breath?
11. Professor Sheila the Baroness Hollins wrote, “It is alarming that awareness of the risks of alcohol consumption during pregnancy remains low, and the needs of those affected continue to go unmet. It is therefore vital that we see stronger commitment and leadership from those who can implement change.” BMA (2016) The National Organisation for FASD calls on the WHO to demonstrate that commitment and leadership by addressing these issues its global strategy on alcohol harm.
12. Leadership from the WHO through inclusion of decreasing alcohol-exposed pregnancies and increased diagnosis and support for those with FASD in the global strategy’s goals and objectives could have a profound impact in setting best practice internationally. For

example, a 2019 study by National Organisation for FASD, based on Freedom of Information requests to all Clinical Commissioning Groups and NHS Trusts in the UK, found that there is an alarming lack of focus by public health and care service providers on FASD. Not one CCG said they have a policy on commissioning services for Foetal Alcohol Spectrum Disorders. Nearly 80% said they do not provide diagnosis for children with FASD. 92% said they do not provide diagnosis for adults. Only 19% of Trusts and Health Boards said that they provide post-diagnostic services for those with FASD.^{vii}

13. That said, key public health entities in the UK are beginning to recognise FASD in a way they have not done before. A clear statement to this effect was made on 17 January 2019 by then health minister Steve Brine, “The Government take alcohol concerns, across the board, very seriously and even more so when they relate to pregnancy. We are making progress—I hope—to prevent future FASD cases, and trying to change the landscape on prevention and treatment for those affected. But there is not an ounce of complacency in us—there certainly is not in me. We will continue to work towards improvements in the area.”^{viii}
14. By ignoring the alcohol harm from alcohol-exposed pregnancies and Fetal Alcohol Spectrum Disorders in this strategy document, the WHO is positioning itself sorely out of synch with leading medical bodies not just in the UK but around the world. It would be ignoring the latest scientific advice and denying the human rights of those with FASD to be seen and heard in key public health messaging.
15. The Scottish Intercollegiate Guidelines Network (SIGN) is part of the Evidence Directorate of Healthcare Improvement Scotland. Its objective is to improve the quality of health care for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. In 2019, SIGN published new guideline on “Children and Young People Prenatally Exposed to Alcohol.” SIGN states on its website, “Alcohol consumption in pregnancy has the potential to cause significant fetal damage... It is estimated that approximately 3.2% of babies born in the UK are affected by fetal alcohol spectrum disorder (FASD), which is three to four times the rate of autism.”^{ix} According to SIGN 156: “FASD is characterised by damage to the developing brain, leading to abnormalities in how the brain works.” “Alcohol can destroy brain cells and damage the nervous system and other organs of the baby at any point during the nine months of pregnancy (including before pregnancy is confirmed).” “There is no known safe level of alcohol consumption during pregnancy. Even low to moderate levels...can negatively impact a fetus and these adverse consequences can persist into adulthood.”
16. Over the past year, England’s National Institute for Health and Care Excellence (NICE) has been working on a Quality Standard on FASD^x. NICE provides national guidance and advice to improve health and social care. This NICE Quality Standard on FASD is currently scheduled to be published in July 2021. It will highlight areas where the quality of care needs to be improved. The present draft highlights the need for improving care in five areas: the advice pregnant women receive, the recording of alcohol-exposed pregnancies in both maternal and child notes, referral for assessment, access to a neurodevelopmental assessment, and a care management plan. NICE emphasises the importance of diagnosis by stating: “Diagnosis at the earliest possible stage allows for early intervention and treatment programmes and a better overall outcome for an individual with FASD.”^{xi}
17. When entities like the WHO fail to focus on the harm caused by alcohol in pregnancy a) those with FASD are denied a proper understanding of their brain-based condition and thus the appropriate support that can be life-changing for them and b) women and families are

failed by not being adequately educated and supported to achieve the best possible outcomes for the pregnancies (in addition to FASD, alcohol exposed pregnancies also have increased risks of infertility, miscarriage, stillbirth, premature birth and Sudden Infant Death Syndrome) (BMA, 2016). It is not enough for the WHO to only cover these risks in publications about pregnancy^{xii} - the topic also should be directly addressed in strategies on reducing alcohol harm (and those that focus on developmental disabilities) if there is to be a comprehensive approach to addressing the magnitude of this public health challenge.

18. Again, according to SIGN 156: "FASD [is] a lifelong disability that requires accommodations and supports to maximise success." "It is critical that FASD is recognised as a physical, behavioural and neurodevelopmental health condition."
19. Not only are people not diagnosed but many are misdiagnosed. "A significant proportion of children currently diagnosed with ADHD or autism may have undiagnosed FASD as an underlying cause of their learning problem." Mukherjee and Cook (2016)^{xiii}
20. The BMA (2016) emphasises: "Following diagnosis it is vital that appropriate treatment and support systems are implemented at the earliest possible stage to ensure the best outcomes for the child and their family, as well as to prevent the onset of secondary problems."
21. The secondary problems that can arise when FASD is ignored can be devastating, including mental health problems, addictions, homelessness, sexual vulnerability, suicide, problems with the legal and justice system, and more.
22. Ignoring FASD comes at a great cost to society. For example NICE (Briefing Paper, 2020) says, "Based on data from the US, the annual cost of FASD in the UK is estimated to be over £2 billion."
23. Birth mothers of those with FASD advocate for increased attention on these issues as silence has devastating impact. As one birth mother said, "It's the right for both the mother and child to have an FASD diagnosis. Diagnosis of Foetal Alcohol Spectrum Disorders is still too difficult to access, even when birth mothers come forward and express their concerns....90% of birth mothers knew within first year that their child was different, yet for some it took till adulthood to get a diagnosis and the impact of a late diagnosis for many have been addiction, mental health, justice systems and sexual exploitation. FASD is sometimes multi-generational – we can break this cycle." Pip Williams, Founder UK-EU Birth Mothers-FASD Network, Co-Founder, FASD UK Alliance, Meeting with Deputy Chief Medical Officer Prof. Gina Radford, 22 October 2018.^{xiv}
24. The WHO should convene a meeting with adults and young adults with FASD and other stakeholders including birth mothers. It's important to hear the voices of those with FASD when considering the impact of prenatal alcohol harm. They are key stakeholders who have a right to be heard.
25. Consider the following quotes from people with FASD in the UK who have been sharing their truths with UK policy makers.
26. "FASD is a time bomb waiting to explode. There must be so many people out there now with wrong diagnosis and without any understanding of what is wrong with them." Adult with FASD in response to survey by the National FASD Advisory Committee, presented at Meeting with Deputy Chief Medical Officer Prof. Gina Radford, 22 October 2018.^{xv}

27. "FASD is complicated and no two people are the alike. Prenatal alcohol exposure can cause damage to any system of the body. In recent medical literature there were found to be over 400 different diagnoses and problems with FASD. Most of the time FASD is invisible. People with FASD can look normal, but struggle with normal day to day tasks. It most common for people with FASD not to have facial features. Most people with FASD will have a normal intelligence. Some will have high intellect and still struggle. The majority will need a circle of external support for their lifetimes. You cannot outgrow FASD. It is permanent and a life-long condition. There is no cure. It is a struggle to find diagnosis, support and help as there is no disability category where they fit into. People with FASD just want to be understood, cared for and most of all loved like everyone else." Andy Jackson, presentation at meeting with Deputy Chief Medical Officer Prof. Gina Radford, 22 October 2018^{xvi}.
28. "My first Primary School teacher described me as being lazy, defiant, obstructive and evil when I was in Year 1. My GP knew nothing about FASD, even though it was suggested at my adoption medical... I saw CAMHS [Child and Adolescent Mental Health Services] last week and they really told me that it's not really their job to support people with my conditions. They couldn't tell me whose job it was....I want people who understand the effects of FASD on minds and mental health...Mental health services who recognise and have services for those affected...Not to be blamed for my conditions, especially when people have been told how these conditions affect me." Georgia Roberts, teen with FASD, Presentation to the All-Party Parliamentary Group on FASD Roundtable Discussion, 13 December 2018^{xvii}.
29. "It's not right...I would like to be diagnosed. I have every right to be diagnosed." Nyrene Cox, adult with suspected FASD who has been trying for 5 years to get a diagnosis, speaking before the All-Party Parliamentary Group on FASD, 9 May 2019.^{xviii}
30. People with FASD want their strengths to be acknowledged as well. They can be part of the solution to some of these challenges. According to Rossi, another of our advisors said, "Life with FASD has its ups and downs, negatives include being globally delayed in comparison to my peers, causing them to see me as childish. A major positive is the fact that I can see what others can't and think outside the box creatively."
31. The National Organisation for FASD has developed a new website funded by the Department of Health and Social Care, as part of a partnership project with Seashell. This website – www.fasd.me – is designed to empower young people with FASD to become better self-advocates and to better understand their condition. As part of this, more than 70 young people with FASD contributed to lyrics for a new song. Please [watch the video and listen to the song](#) before you decide to not include FASD in your global strategy on reducing alcohol harm. We asked young people what they want the world to know about living with FASD. Here is an excerpt:

I see the world with different colours

And I play a different way to the others

The alcohol got in my brain

But I still laugh and smile the same

Because of my pain it's like Groundhog Day, Groundhog day, Groundhog Day.

Every life is precious, that's easy to see

I want to show you all my skills, to show the world me

I can feel safe and free

I know that I'll get there

Walk along with me^{xix}

32. The National Organisation for FASD (UK) calls upon the WHO to walk along with those with FASD and their families. Silence is not acceptable on such a major, overlooked and preventable condition.
33. The National Organisation for FASD stands ready to assist in further development of the WHO global strategy to reduce the harmful use of alcohol, including helping to organise a stakeholder meeting.

Sources:

ⁱ The National Organisation for FASD (formerly NOFAS-UK) is dedicated to supporting people affected by Fetal Alcohol Spectrum Disorders (FASD), their families and communities. It promotes education for professionals and public awareness about the risks of alcohol consumption during pregnancy. National FASD, founded in 2003, is a source for information on FASD to the general public, press and to medical and educational professionals. UK registered charity number 1101935. (For more information see our three websites: www.nationalfasd.org.uk; www.preventfasd.info; www.fasd.me)

ⁱⁱ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5839298/>

ⁱⁱⁱ <https://www.ontario.ca/laws/statute/S04012>

^{iv} https://www.euro.who.int/_data/assets/pdf_file/0005/318074/Prevention-harm-caused-alcohol-exposure-pregnancy.pdf?ua=1

^v BMJ (2020): <https://www.bma.org.uk/what-we-do/population-health/drivers-of-ill-health/alcohol-and-pregnancy-preventing-and-managing-fetal-alcohol-spectrum-disorders>

^{vi} BMA (2016): <https://www.bma.org.uk/what-we-do/population-health/drivers-of-ill-health/alcohol-and-pregnancy-preventing-and-managing-fetal-alcohol-spectrum-disorders>

^{vii} <https://nationalfasd.org.uk/learn-more/policy/ccgs-and-nhs-trusts/>

^{viii} [https://hansard.parliament.uk/commons/2019-01-](https://hansard.parliament.uk/commons/2019-01-17/debates/19011751000002/FoetalAlcoholSpectrumDisorder)

[17/debates/19011751000002/FoetalAlcoholSpectrumDisorder](https://hansard.parliament.uk/commons/2019-01-17/debates/19011751000002/FoetalAlcoholSpectrumDisorder)

^{ix} <https://www.sign.ac.uk/sign-156-children-and-young-people-exposed-prenatally-to-alcohol>

^x <https://www.nice.org.uk/guidance/indevelopment/gid-gs10139/documents>

^{xi} NICE briefing paper, <https://www.nice.org.uk/guidance/indevelopment/gid-gs10139/documents>

^{xii} See for example, <https://www.who.int/publications/i/item/9789241549912> and

<https://www.who.int/publications/i/item/9789241548731>

^{xiii} <https://theconversation.com/how-foetal-alcohol-spectrum-disorders-could-be-a-hidden-epidemic-52835>

^{xiv} https://nationalfasd.org.uk/documents/20181022_Roundtable%20DeputyCMO_FIN.pdf

^{xv} https://nationalfasd.org.uk/documents/20181022_Roundtable%20DeputyCMO_FIN.pdf

^{xvi} https://nationalfasd.org.uk/documents/20181022_Roundtable%20DeputyCMO_FIN.pdf

^{xvii} https://nationalfasd.org.uk/documents/20181213_APPG_FASD_PrevalenceReptRev.pdf

^{xviii} <https://business.facebook.com/nofasuk/videos/820275065009894/>

^{xix} <https://fasd.me/funzone/music/walk-along-with-me/>

The Scotch Whisky Association

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

Submission

1. This is a submission on behalf of the UK alcoholic drinks trade associations: British Beer & Pub Association, National Association of Cider Makers, Scotch Whisky Association and Wine and Spirit Trade Association. Our membership ranges from small family run businesses up to multi-national companies. The industry, including the hospitality sector, directly supports more than 3 million jobs and generates more than £70 billion of GVA (gross value added) directly to the UK economy.

2. We have read the working document for development of an action plan to strengthen implementation of the Global Alcohol Strategy to reduce the harmful use of alcohol. We thank the WHO Secretariat for the work they have put into to developing this draft and the opportunity to provide comments which are set out below. We ask you to take these into consideration in the ongoing process to develop the action plan. We have set on general points below, more specific points are include in our attached submission.

General Points

3. It is important the action plan is consistent with the Global Alcohol Strategy and continues to focus on harmful consumption. The responsible enjoyment of alcoholic beverages is not incompatible with a balanced lifestyle and the majority of adults that choose to drink alcohol do so without harm to themselves and others.

However, we note there is an inconsistency in terminology throughout the draft where sometimes it refers to consumption per se as opposed to harmful consumption. For example, operational objective 4 of the action plan states 'Raise awareness of risks and harms associated with alcohol consumption at all levels as well as of effectiveness of different policy options to reduce consumption and related harm. This is clearly inconsistent with the Global Alcohol Strategy. Similarly, the suggested global target 1.2 states 'at least a relative reduction in alcohol per capita consumption by 2025'. The success or failure of the Global Alcohol Strategy will be measured by its impact on harmful consumption: the action plan's target should be a relative reduction in harmful consumption.

4. We consider it essential that individual Member States retain the flexibility to address the issue of harmful drinking according to their own national priorities and that they can make use of the comprehensive menu of policies as set out in the Global Alcohol Strategy. As the action plan notes, the aim of the Global Alcohol Strategy is to give guidance for actions at all levels; to set priority areas for global action; and to recommend 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. However, action area 1 focuses on promoting a specific set of policies to the exclusion of all others. We do not support a 'one size' fits all approach, which we consider it to be inconsistent with the Global Alcohol Strategy.

5. We welcome the recognition of a ‘whole of government’ and ‘whole of society’ approach within the action plan. The alcohol industry has an important and positive role to play in the action plan consistent with the Global Alcohol Strategy and the 2018 UN Political Declaration on Non-Communicable Diseases. We consider this is an approach that should be delivered at national, regional and global levels. Whilst we note the action plan sets out proposed actions for economic operators under the different action areas, it also isolates and marginalizes the industry and uses languages which frames the industry as more part of the problem and a barrier to progress rather than as part of the solution. This is inconsistent with a whole of society approach, which is disappointing.

6. The industry can and does make an important contribution to reducing harmful drinking. In the UK, partnership working with the industry provides an important contribution to overall efforts to tackling harmful drinking. Examples include the Responsibility Deal, which helped stimulate an increased availability to consumers of non- and lower- alcohol alternatives. Supporting initiatives such as Challenge 21 and 25, anti-drink drive campaigns, voluntarily providing consumers with more information on calories and ingredients, supporting communication of the Chief Medical Officers’ low risk drinking guidelines. Supporting Local Alcohol Action Areas by introducing schemes to support them, such as, Pubwatch, Best Bar None, Community Alcohol Partnerships, Purple Flag which are all complementary industry funded schemes designed to reduce harm. The Scottish Government in its 2018 Alcohol Framework welcomed industry initiatives to prevent underage drinking, such as our proxy purchase campaign and campaign to promote smaller wine measure in pubs.

7. In the UK, Drinkware the independent charity working to reduce alcohol misuse and harm helps people to make better choices about their alcohol consumption by providing facts, tools and advice to measure and regulate their intake. Its website received 8 million unique visitors in 2019. It also ran a Drink Free Days campaign in partnership with Public Health England a key message of the Chief Medical Officer’s low risk drinking guidelines. This campaign continues, its latest iteration is ‘No More Excuses’ – details can be found here.

8. We note the WHO Secretariat has set out a significant number of targets and actions within the draft action plan. We recognise the importance of having targets and actions. However, we believe it is for Member States to determine the targets and supporting actions as it will be important not to spread activity too thinly across multiple targets.

Attachment(s): 1

00243_42_action-plan-ta-sub1120-final.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

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General Points

3. It is important the action plan is consistent with the Global Alcohol Strategy and continues to focus on harmful consumption. The responsible enjoyment of alcoholic beverages is not incompatible with a balanced lifestyle and the majority of adults that choose to drink alcohol do so without harm to themselves and others.

However, we note there is an inconsistency in terminology throughout the draft where sometimes it refers to consumption per se as opposed to harmful consumption. For example, operational objective 4 of the action plan states '*Raise awareness of risks and harms associated with alcohol consumption at all levels as well as of effectiveness of different policy options to **reduce consumption** and related harm.*' This is clearly inconsistent with the Global Alcohol Strategy. Similarly, the suggested global target 1.2 states 'at least a relative reduction in alcohol per capita consumption by 2025'. The success or failure of the Global Alcohol Strategy will be measured by its impact on harmful consumption: the action plan's target should be a relative reduction in harmful consumption.

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8. We note the WHO Secretariat has set out a significant number of targets and actions within the draft action plan. We recognise the importance of having targets and actions. However, we believe it is for Member States to determine the targets and supporting actions as it will be important not to spread activity too thinly across multiple targets.

Specific points relating to the Draft Action Plan

Setting the Scene

Progress in Tackling Harmful Drinking

9. Under the Global Alcohol Strategy there has been significant progress in reducing harmful drinking as shown by the [WHO's 2018 Global Status Report on Alcohol and Health](#).

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%

10. We welcome the references in the draft action plan to the progress made under the Global Alcohol Strategy:
 - Consumption per capita has decreased in the European region, surpassing the target set in the global monitoring framework for NCDs .

- Age-standardization prevalence of heavy episodic drinking decreased globally from 20.6% in 2010 to 18.5% in 2016 among the total population, although remained high in some parts, namely Eastern Europe and some sub-Saharan countries.
- Consumption among young people has reduced in many countries in Europe and in some high-income societies.

This data is very welcome and helps to recognise that progress has been made. We agree that more needs to be done but the progress made should provide a platform for the action plan to build on.

COVID-19

11. The world has been rocked by the pandemic. We would agree the impact of the pandemic on the levels and patterns of alcohol consumption and related harm worldwide still needs to be assessed. In the UK we expect overall consumption to be reduced primarily due to large parts of the on-trade being locked down. Data collected by the market research company Nielsen indicates that during lockdown there was an increase in alcohol sales in UK supermarkets, but a decline in overall alcohol consumption. During a 17-week period covering lockdown to 11 July in the UK, consumers spent £7.7 billion on alcohol in UK supermarkets, compared to £5.8 billion last year. However, because of restrictions on on-trade purchases, it is reported that Britons purchased 1.3 billion litres of alcohol during the period, compared to 2 billion litres last year. A reduction of 35%.

12. We would suggest caution is applied and that alcohol policies should not be developed based on experiences during COVID.

13. Tackling COVID has shown the importance of a whole of society approach. The industry has worked collaboratively with government and other stakeholders to support efforts in responding to the crisis. This has included production of hand sanitisers, supporting local communities and the safe re-opening of the on-trade. More details can be found [here](#).

Framework Convention

14. The draft document notes the background which led to the calls for a global normative law based on the Framework Convention on Tobacco, but fails to mention that at the 146th Session of the Executive Board the idea was rejected and the Board's decision was to recognise the

continued relevance of the Global Alcohol Strategy and develop an action plan to support its effective implementation. This consultation is part of the process of developing that action plan.

Operational principles for global action:

15. A number of principles are set out for consideration. One of the principles is protection from commercial interests. We believe this should be replaced with a principle that states 'appropriate consideration and management of conflict of interest' based on the Framework for Engagement with non-state actors.

Action Area 1: Implementation of High Impact Strategies and Interventions

16. The introductory sections of the draft working document refer to the aims of the Global Alcohol Strategy to recommend 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. It also acknowledges that tackling harmful consumption is a complex problem and there are differences in cultural norms and contexts. However, what is proposed in action area 1 completely ignores these principles and instead puts forward and promotes a specific set of policy options to the exclusion of others in the form of the SAFER technical package – a 'one size' fits all approach. This undermines the approach agreed in the Global Alcohol Strategy and devalues the other interventions which may be more relevant in a particular national context. Moreover, as far as we are aware Member States have not endorsed the SAFER initiative.
17. Supporting Member States to assess the issue of harmful consumption and enable them to place that into the context of their own national circumstance thereby allowing them to act accordingly in the knowledge of the full set of policy options under the Global Alcohol Strategy is a much more appropriate approach. It offers flexibility rather than a rigid approach which recommends a narrow set of policy actions which may not be relevant. The UK provides a useful example. The individual nations of the United Kingdom each have their own unique approach to tackling harmful drinking due to the existence of overarching national strategies alongside targeted localised interventions, which differ dependent on regions, their specific needs and the devolved powers available to each of them. This allows them to tailor their policy response to address the issue of harmful drinking that best suits their needs.

18. To set a target which only focuses on assessing the implementation of a specific set of policy options is inconsistent with the Global Alcohol Strategy. Tackling harmful consumption is a complex issue; such issues are not solved by a one size fits all approach. A balanced, multi-component approach sensitive to national context and culture is the way forward. Again, we would draw your attention to the initiatives highlighted in paragraph 6 above that have made an important contribution to the reduction of harmful drinking in the UK.
19. In the scene setting section of the working document it states, 'Informally and illegally produced alcohol account for an estimated 25% of total alcohol consumption per capita worldwide and, in some jurisdictions, exceeds half of all alcohol consumed by the population.' We know that illicit alcohol production is associated with significant health risk. There are many examples of this. For example, in June this year the Dominican Republic reported over 200 deaths caused by illicit alcohol. In countries where this is the case focusing on the SAFER package of policy measures would seem inappropriate as it would not be addressing the issue most relevant to that national context and could divert limited resources. We believe more attention should be given to this in the action plan, especially as many of the SAFER policy options have no impact on such a significant part of harmful consumption. Moreover, recent research has called into questions the effectiveness of a number of the policies in the SAFER package the so called 'best buys'; namely increasing tax, banning or restricting advertising and reducing availability, in low- and middle-income countries.^{1,2}

Action Area 2: Advocacy, Awareness and Commitment

20. We are committed to playing our part to tackle harmful drinking. Making consumers aware of the dangers associated with harmful consumption is something the industry helps with and it also supports health colleagues with amplifying key messages. In the UK, through Drinkaware, a whole suite of advice and tools are made available to allow consumers to assess their drinking and how to cut back as well advice on the negative consequences to health and how to get help. Drinkaware has in place an independent [Medical Advisory Panel](#) to ensure their information and advice is based on the most current medical evidence. Drinkaware launched a successful campaign in 2018

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.

with Public Health England to promote alcohol free days which is key part of the UK Chief Medical Officers' low risk drinking guidelines. The evaluation of the campaign can be found [here](#). A campaign which continues to run and be developed today.

21. The proposed action relevant to economic operators under this action area states '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, ...'. Responsible marketing is a key deliverable for the industry. The industry puts significant effort into protecting minors from alcohol advertising through codes of practice at the company, sectoral, national and global level supported by codes on responsible retailing.
22. This proposed action also states economic operators should 'refrains from promoting drinking, ...' which suggests that we should stop marketing our products. As we have already noted, most people who choose to drink do so without harm to themselves or others. In the UK we have a co-regulatory system to regulate alcohol advertising which is very effective. Marketing bans have not been shown to be effective in reducing harmful drinking.
23. We also note a number of proposed actions are set out for the WHO Secretariat. One relates to developing an international standard for labelling alcoholic beverages. Including information on labels is a policy option identified within the Global Alcohol Strategy for Member States to consider. Requesting the WHO Secretariat develop an international standard is not within its scope and we therefore consider this action to be inconsistent with the Global Alcohol Strategy. We would also note the labelling of alcoholic beverages is part of an ongoing discussion within a different multilateral process under CODEX. The next meeting of the CODEX Committee on Food Labelling looking at this issue will take place in September 2021. Therefore, we do not see the need to start a separate multilateral process on this issue.
24. Action proposed for the WHO Secretariat under this action area, but also under action area 3, relates to international trade negotiations. On the multilateral level international trade comes under the competence of the World Trade Organisation (WTO). Under WTO rules a Member State can undertake any action which they see fit to address harmful drinking as long as measures adopted are equally applicable to domestic products as they are to imported ones. The measures

must be the least trade restrictive possible. We therefore question the inclusion of proposals on international trade in the action plan.

Action Area 3: Partnership, Dialogue and Coordination

25. We believe that partnership working is fundamental to reducing harmful drinking and must include all relevant stakeholders, including the industry. That has been the approach successfully adopted in the UK for many years as part of a 'whole of society' approach. We therefore welcome the recognition of a 'whole of government' and 'whole of society' approach within the action plan. As mentioned above, we are concerned that some of the language used would seem to wish to exclude the industry. Denying the full involvement of the industry would deny access to the industry's expertise and resources. We hope this will be rectified as the action plan is developed.
26. We have always been clear that governments set alcohol policy. However, we believe that governments, when considering new policy, should consult with all relevant stakeholders including the alcohol industry.
27. We welcome the annual dialogue that has been established between the WHO Secretariat and economic operators over the past few years. Such dialogues happen on a regular basis within the UK and we would suggest it happens at national, regional and the global level.
28. The topic of digital marketing comes up at several points throughout the draft document, including this section of the draft action plan. As the world becomes more digital and consumers digest more information digitally like many other industries we have invested in digital communication. However, the document seems to suggest that this is an unregulated space. That is not the case in the UK: the Advertising Standards Authority has responsibility for regulating digital advertising in the same way as it regulates more traditional media.
29. There is no denying that technology is developing rapidly, and consumer preferences are an ever-changing feast. It is therefore important to note that digital marketing is a focus for the industry to ensure that relevant standards and protocols are developed to ensure responsible advertising. The International Alliance for Responsible Drinking (IARD) is working with the social media platforms to ensure technological solutions are incorporated to protect minors from seeing or interacting with alcohol adverts and to give consumers the choice to block alcohol marketing if

they do not wish to see it. Details can be found [here](#). Working with the social media platforms means that such measure will have a global reach.

30. A proposed action for economic operators is to ‘abstain from interfering with alcohol policy development and evaluation.’ It is important to note that evaluation is very important to the industry especially in relation to the programmes we support and deliver.
31. Evaluation is a key part of policy development. It is worth noting that rather than excluding industry from the evaluation process in Scotland under the ‘Monitoring & Evaluating Scotland’s Alcohol Strategy: MUP evaluation’ the industry is an important contributor and integral part of the evaluation process.

Action Area 5: Knowledge Production and information

32. We agree there should be a consistent and regular monitoring of trends in alcohol-related harm and consumption.
33. Under the Non-Communicable Disease agenda, the global target is a 10% relative reduction in the harmful use of alcohol by 2025 (2010 baseline), as appropriate, within the national context.
34. The agreed indicators are:
- a. Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context;
 - b. Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context;
 - c. Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context.

Data on all three indicators should be gathered.

35. It is our view that total alcohol per capita (APC) consumption alone is inadequate as an indicator of progress in reducing the harmful use of alcohol. APC is an aggregate measure; it does not differentiate between light, moderate, and heavy drinking, but simply reports averages.

36. Industry can also support government and independent third parties (e.g. NGOs, academia) in efforts to collect data and trends. A key area would be tracking the illicit market.

Action Area 6: Resource Mobilization

37. Taxation is an issue which is referred to several times throughout the draft action plan, including this chapter. We support appropriate levels of taxation. A level of taxation that adequately reflects the local context will bring unrecorded alcohol into the tax fold, thereby increasing government revenues and targeting the cost-appeal of illicit goods and reducing the risk of these products to public health.
38. The draft action plan floats the idea of an intergovernmental commitment to a global tax on alcohol to be governed internationally. There is no mention of how it would be governed or of WHO's competency in taxation matters. Taxation is the competency of Member States and should remain so.
39. The issue of earmarked taxes is also raised. However, we would note there is an ongoing debate on the pros and cons of such taxes³.
40. The issue of funding research is also addressed under this action area. A proposed action for economic operators is not to fund research in the public health, policy-related space. We would suggest that is a very narrow view. Funding for research is scarce. We think it would be more fruitful to invest in protocols and safeguards to ensure issues around conflicts of interest are addressed to allow industry support for research to assess the efficacy of interventions and the effectiveness of implementation.

December 2020

³ See link https://www.who.int/health_financing/topics/public-health-taxes/for-against-sin-tax/en/

Turkish Green Crescent

Department/Unit: *International Cooperation*

Country/Location: Turkey

URL: greencrescent.org

Submission

Lack of Resources to Support the Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol Especially in LMICs

One of the key areas of the Global Action is “resource mobilization” that is not limited to funding; but that includes technical capacity and human resources especially in low and middle-income countries. In this regard, we are happy to see a global action area allocated to resource mobilization and would like to emphasize the need for philanthropic funding in all WHO regions in a fair and just manner, and also technical expertise in order to ensure capacity-building in low and middle-income countries. We would also like to highlight the importance of international collaboration and research in this area, and civil society engagement at the international level to reduce the global health burden alcohol uses poses on our health systems. We are happy to see health emergencies and its toll such as the COVID pandemic and the SDGs are mentioned; and would like to call WHO to allocate a separate section on the complex humanitarian emergency situations and the need for action to reduce the toll alcohol addiction has on people struggling with such emergencies.

Necessity of a Global Normative Law on Alcohol at the Supranational Level, Modelled on the WHO Framework Convention on Tobacco Control

Alcohol consumption, being responsible for 3 million people’s death globally in a year, and making up more than 5% of the global burden of disease needs to be subjected to a global normative law at the international level, which could be modelled on the WHO Framework Convention on Tobacco Control. As a result of insufficient legal frameworks on the national and subnational levels; alcohol remains to be susceptible to interference from transnational commercial interests and institutions. Furthermore, very few civil society institutions put alcohol-related harm in their agenda; contrary to what they normally do with tobacco. We would therefore like to highlight the need for the international community to focus on the development of a global normative law that would regulate the production, distribution, sale and marketing of alcohol across borders.

Making Reference to the Fact that in Many Cultures and Populations Non-Drinking is the Norm

The guiding principles of the Global Strategy to Reduce the Harmful Use of Alcohol include being equitable and sensitive to national, religious and cultural contexts; we support the emphasis placed on this as it would be important to take into account the cultural differences while measuring and ensuring policy coherence as well as when implementing strategies and implementations on the national and subnational level, that are based on the latest available scientific evidence and best practices accumulating from social, cultural and economic contexts. In addition to that, we would like to draw the attention to the many cultures and populations that have non-drinking as a cultural and social norm. We call WHO to focus on the health, social and economic consequences of the activities of the alcohol industry and the outcomes of its commercial activities in majority non-drinking countries.

Implementation and Evaluation of Potentially Effective Policies and Actions in Low and Middle-Income Countries

Development and implementation of written national alcohol control policies are essential for the regulation of alcohol production, distribution, sales and consumption among states. However, the development and implementation of such policies have been lacking for the most part in low-income countries while they are being implemented more and more, and being revised depending on the evaluation of their outcomes in high-income countries. This is a concerning situation that is also stated in the working document as it raises questions about the equitability of health systems across our globe. Therefore, we would like to highlight the need for such policies, and also the need for their implementation to be monitored and evaluated for revision purposes by a committee of international technical experts while not undermining the sovereignty of states.

Highlighting the Need for Accountability Measures to be Included in the Action Plan

Civil society and the Academia is invited to get engaged in advocacy and policy areas under the first Action Area titled “Implementation of high-impact strategies and interventions”; they are called to work for the creation of enabling environments, promotion of the SAFER initiative, strengthening of global and regional networks and action groups, development and strengthening of accountability frameworks as well as monitoring activities and commitments of economic operators in alcohol production and trade. While we fully support that the civil society and the Academia need to work on alcohol issues in an inter-sectoral approach, we also defend that we always need to keep the alcohol industry’s potential areas of interest in mind. Therefore, we emphasize that the accountability and monitoring measures and frameworks need to be effectively included in the Action Plan; and because of the urgency of alcohol-related harm as a public health threat, without too much delay.

Attachment(s): 1

00412_55_who working document consultation-tgcs-opinions.pdf

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Implementation and Evaluation of Potentially Effective Policies and Actions in Low and Middle-Income Countries

Development and implementation of written national alcohol control policies are essential for the regulation of alcohol production, distribution, sales and consumption among states. However, the development and implementation of such policies have been lacking for the most part in low-income countries while they are being implemented more and more, and being revised depending on the evaluation of their outcomes in high-income countries. This is a concerning situation that is also stated in the working document as it raises questions about the equitability of health systems across our globe. Therefore, we would like to highlight the need for such policies, and also the need for their implementation to be monitored and evaluated for revision purposes by a committee of international technical experts while not undermining the sovereignty of states.

Highlighting the Need for Accountability Measures to be Included in the Action Plan

Civil society and the Academia is invited to get engaged in advocacy and policy areas under the first Action Area titled *“Implementation of high-impact strategies and interventions”*; they are called to work for the creation of enabling environments, promotion of the SAFER initiative, strengthening of global and regional networks and action groups, development and strengthening of accountability frameworks as well as monitoring activities and commitments of economic operators in alcohol production and trade. While we fully support that the civil society and the Academia need to work on alcohol issues in an inter-sectoral approach, we also defend that we always need to keep the alcohol industry’s potential areas of interest in mind. Therefore, we emphasize that the accountability and monitoring measures and frameworks need to be effectively included in the Action Plan; and because of the urgency of alcohol-related harm as a public health threat, without too much delay.

U.S. Alcohol Policy Alliance

Country/Location: United States of America

URL: www.alcoholpolicy.org

Submission

The U.S. Alcohol Policy Alliance appreciates the opportunity to provide feedback on this important document. Overall, we recommend that the actions and targets should be made as specific and operationalized as possible, with concrete and measurable targets that are reviewed by the Director General in a biennial report on the progress of the plan. Additionally, we encourage the prohibition of any involvement in efforts to reduce the harmful use of alcohol by those with commercial interests in alcohol. If these entities must be engaged in this process, we recommend it be limited in both scope and purpose, and with complete transparency of their engagement – including the specifics of the input solicited, received, and incorporated. We provide concrete suggestions in the attached document as well.

Attachment(s): 1

00273_50_response-to-the-world-health-organization-action-plan-usapa.pdf



Response to the World Health Organization's Action Plan to strengthen the Implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

The U.S. Alcohol Policy Alliance (USAPA) is grateful to the World Health Organization for developing the Action Plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. We are pleased to submit our recommendations to further improve this document. Overall, we recommend that the actions and targets should be made as specific and operationalized as possible, with concrete and measurable targets that are reviewed by the Director General in a biennial report on the progress of the plan.

Additionally, we encourage the prohibition of involvement by those with commercial interests in alcohol. If these entities must be engaged in this process, we recommend it be limited in both scope and purpose, and with complete transparency of their engagement – including the specifics of the input solicited, received, and incorporated.

Below we provide our suggestions and feedback by each section of the working document.

SETTING THE SCENE

1. **Working Document (Box 1 – Aims):** “to give guidance for actions at all levels; to set priority areas for global action”
 - a. **USAPA Response:** We agree that it is important for there to be comprehensive and coordinated global action to reduce the harms associated with alcohol use. The need for an international framework on alcohol use should be made more explicit throughout this document, including in many of the Operational Objectives of the Action Plan as well as the Key Areas for Global Action.
2. **Working Document Sentence (pg. 3):** “Overall – despite some decreasing trends in alcohol consumption 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 alcohol-related morbidity and mortality and the ensuing social consequences.”
 - a. **USAPA Response:** Providing more specific trends and implementation data on the high and low performing states would allow advocates to be more informed and present concrete data to their lawmakers. We also recommend that the working document specifically refer to the lack of resources at the region/country level as a driving factor for low implementation.
3. **Working Document Sentence (pg. 4):** “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”

- a. **USAPA Response:** WHO should explicitly recognize the need for a binding international framework on alcohol control, similar to the WHO Framework Convention on Tobacco Control.
4. **Working Document (pg. 5):** “Limited technical capacity, human resources and funding hinder efforts in developing, implementing, enforcing and monitoring effective alcohol control interventions at all levels.”
 - a. **USAPA Response:** We support this observation and recommend that WHO more explicitly call for Member States to dedicate more funding for alcohol prevention and policy research, including resources to engage citizen stakeholders.
5. **Working Document (pg. 5):** Page 5 does a nice job of detailing many of the consequences of alcohol use on morbidity and mortality.

USAPA Response: The scientific link between alcohol and cancer is strong, and we believe this association should be specifically mentioned in this background section to draw further attention to it. There are seven different types of cancer that have been associated with alcohol use, and these should be detailed in the document: mouth, larynx, pharynx, esophagus, liver, colon and rectum, and breast.
6. **Working Document (pg. 5):** “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 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.”
 - a. **USAPA Response:** This paragraph does not seem to lend much to the conversation, given the limited evidence around recreational activities as alternatives to drinking and the role social media plays in this messaging. At a minimum, we recommend it be reworded or moved to the end of this section on “Opportunities for Reducing Harmful Alcohol Use”.

GOAL OF THE ACTION PLAN

1. **Working Document (pg. 7):** “Effective implementation of the action plan at regional levels may require development or elaboration and adaptation of region-specific action plans.”
 - a. **USAPA Response:** The need for regional action plans is critical and should be reflected more strongly. We recommend replacing “may” with “will” in the identified sentence, so it reads “Effective implementation of the action plan at regional levels will require development of elaboration and adaptation of region-specific action plans.”

PROPOSED OPERATIONAL OBJECTIVES FOR THE ACTION PLAN, GUIDING PRINCIPLES AND KEY AREAS FOR GLOBAL ACTION

1. **Working Document (pg. 9):** Operational Objectives of the Action Plan
 - a. **USAPA Response:** Across each of the operational objectives, concrete accountability measures should be included to measure progress against these objectives.

2. **Working Document (pg. 10 – Principle 2):** “Policies should be equitable and sensitive to national, religious and cultural contexts.”
 - a. **USAPA Response:** We agree that this is a very important point, and recommend that the document specifically refer to an equity-based approach to alcohol control directly in this principle.
3. **Working Document (pg. 10 – Principle 4):** “Public health should be given proper deference in relation to competing interests and approaches that support that direction should be promoted.”
 - a. **USAPA Response:** We again applaud the WHO for including this important principle, but believe this statement should be stronger and explicitly protect all components of the Action Plan from commercial interests.

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

1. **Working Document (pg. 12 – Action 2 for Member States):** “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.”
 - a. **USAPA Response:** We support this important action and encourage the statement be stronger to read “and are free from interference from commercial interests.”
2. **Working Document (pg. 12- Action 2 for WHO Secretariat):** “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.”
 - a. **USAPA Response:** We recommend a more specific time frame for review of the evidence than “periodically” (e.g., every five years).
3. **Working Document (pg. 12- Action 3 for WHO Secretariat):** “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.”
 - a. **USAPA Response:** We recommend taking this opportunity to explicitly call for the development of a binding international framework on alcohol control.
4. **Working Document (pg. 12- Action 3 for Non-State Actors):** “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.”
 - a. **USAPA Response:** It should be made clear that economic operators should not be funding research, given the industry’s emphasis on funding studies that support their claim of “responsible drinking”. We encourage this action instead to recommend that civil society and academia not engage in formal or informal partnerships with economic operators or to accept funding from economic operators.

ACTION AREA 2: ADVOCACY, AWARENESS AND COMMITMENT

1. **Working Document (pg. 14 – Action 6 for Member States):** “Increase awareness of the health risks of alcohol use and related overall impact on health and wellbeing 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.”

- a. **USAPA Response:** We support the need for member states to increase awareness of the health, safety, and equity risks associated with alcohol use, as well as countering misinformation largely disseminated by commercial interests. However, we believe that a national awareness day should be revised to an alcohol awareness week that is directly tied to concurrent policy efforts, given the limited evidence of effectiveness of awareness and education campaigns operating in isolation from a broader approach.
2. **Working Document (pg. 14 – Action 4 for WHO Secretariat):** “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.”
 - a. **USAPA Response:** Global Status reports on alcohol should be prepared and disseminated more frequently to check progress against the goals set forth in this action plan. Tobacco status reports are released every two years, and we recommend alcohol reports be prepared on the same schedule.
3. **Working Document (pg. 14 – 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.”
 - a. **USAPA Response:** We support the need to discuss trade and investment agreements, but do not understand the explicit action described here. We recommend additional clarity.
4. **Working Document (pg. 14 – Action 2 for Non-State Actors):** “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 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.”
 - a. **USAPA Response:** The sole responsibility for monitoring and reporting commercial interest involvement in alcohol research and reduction efforts cannot be on non-state actors. The WHO Secretariat has an important role to play here, and an action that specifies this role should be added under Action 7, for the WHO Secretariat. The action area should include coordinating the collection and dissemination of this information to Member States and Non-State Actors.
5. **Working Document (pg. 14 – Action 3 for Non-State Actors):** “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 from promoting drinking, eliminate and prevent any 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 and contraindications for alcohol use).”

- a. **USAPA Response:** It should be made clear that economic operators should not be funding research, given the industry’s emphasis on funding studies that support their claim of “responsible drinking”. We encourage this action instead to recommend that civil society and academia not engage in formal or informal partnerships with economic operators or to accept funding from economic operators.

ACTION AREA 3: PARTNERSHIP, DIALOGUE AND COORDINATION

1. **Working Document (pg. 16 – Action 2 for Non-State Actors):** “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.”
 - a. **USAPA Response:** The sole responsibility for monitoring and reporting commercial interest involvement in alcohol research and reduction efforts cannot be on non-state actors. The WHO Secretariat has an important role to play here, and an action that specifies this role should be added under this Action Area.
2. **Working Document (pg. 16 – Action 3 for Non-State Actors):** “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.”
 - a. **USAPA Response:** We agree and support this action, but we believe it should be rewritten to say “refrain from engaging in and interfering with” alcohol policy development and evaluation.
3. **Working Document (pg. 16 – Action 6 for WHO Secretariat):** “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.”
 - a. **USAPA Response:** We recommend high levels of transparency around this process, including the publication of agendas in advance of the dialogues and meeting notes within one month of the dialogues.

ACTION AREA 4: TECHNICAL SUPPORT AND CAPACITY-BUILDING

1. **Working Document (pg. 18 – Action 7 for the 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.”

- a. **USAPA Response:** We support the recommendations for monitoring and reporting, but recommend a broader mandate be provided by revising to “and provide recommendations on the way forward.” (i.e., removing “to strengthen the implementation of the Global Strategy”)

ACTION AREA 6: RESOURCE MOBILIZATION

1. **Working Document (pg. 22 – Action 6 for WHO Secretariat):** “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.”
 - a. **USAPA Response:** While we agree that additional resources are needed to support implementation of the Global Strategy in low- and middle-income countries, we strongly recommend this language explicitly state that this funding will not come from economic operators and will remain free from commercial interests.
2. **Working Document (pg. 22 – Action 1 for Non-State Actors):** “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.”
 - a. **USAPA Response:** We support this important action and encourage UN agencies to remain independent of alcohol industry funding, including social responsibility initiatives. We know that many transnational alcohol companies have provided funding to UN agencies in the past through corporate social responsibility initiatives. The need for this independence should be clearly highlighted.
3. **Working Document (pg. 22 – Action 3 for Non-State Actors):** “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.”
 - a. **USAPA Response:** It should be made clear that economic operators should not be funding research or the implementation of measures, given the industry’s emphasis on funding studies that support their claim of “responsible drinking”. We encourage this action explicitly state that that anyone working to reduce the harmful use of alcohol, from prevention to treatment to research, not accept funds or engage in formal or informal partnerships with economic operators.

The U.S. Alcohol Policy Alliance (USAPA) is a nonprofit, nonpartisan organization translating alcohol policy research into public health practice. The Alliance is committed to ensuring that local and statewide organizations engaging in alcohol policy initiatives have access to the science, resources and technical assistance, including support for organizing efforts, required to engage in informed decisions and actions in translating alcohol policy research into public health practice.

UK FASD Research Collaboration

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

Submission

Although we are pleased to see the recommendations in this draft strategy document, we believe the omission of any mention of the harm caused by alcohol consumption in pregnancy is significant. Prenatal alcohol exposure can lead to fetal alcohol spectrum disorders - a highly prevalent and life-long range of neurodevelopmental disorders that are characterised by a wide range of cognitive and behavioural difficulties and adverse life outcomes. There is emerging evidence of effective interventions for prevention, treatment and support but FASDs are currently under-acknowledged and under-recognised. We strongly recommend the WHO acknowledges the scale of this issue and includes recommendations for FASD prevention and mitigation policies in their global strategy to reduce the harms associated with alcohol use.

Attachment(s): 1

00414_56_uk-fasd-rc-response-to-who-alcohol-strategy.pdf

To whom it may concern

We are pleased to see that the World Health Organisation is in the process of publishing this global strategy to reduce the damage caused by alcohol consumption, which highlights the harmful effects of alcohol on disease and death, and its impact on economies and societies around the world. However, we wish to draw attention to what we believe is a significant omission. Although the draft report identifies several important aspects of alcohol-related harm, there is no mention of the damage caused by alcohol consumption during pregnancy. This is a key area of health promotion at the intersection between Non-Communicable Disease prevention and Maternal and Child Health, and in line with United Nations Sustainable Development Goals (SDG3)(1).

Prenatal alcohol exposure can cause fetal alcohol spectrum disorders (FASD), which have an estimated prevalence of around 1% globally(2), and up to 5% in many western countries(2-4). FASD is a lifelong neurodevelopmental condition characterised by learning difficulties(5), executive dysfunction(6), sensory processing difficulties(7), adaptive dysfunction(8), problems with social cognition and social communication(9), and emotional dysregulation(10). Individuals with FASD are at increased risk of unemployment(11), reduced life expectancy(12), mental health disorders(13), involvement with the criminal justice system(14), and can require ongoing support across health, education and social systems(15). Around 10% of individuals with FASD also have craniofacial dysmorphism(4).

Higher levels of alcohol consumption, and especially binge drinking, are associated with more severe outcomes(16), but no safe level has been identified(17, 18). For this reason, the safest advice on alcohol consumption in pregnancy is abstinence. FASD appears to be especially common in looked after and adopted children(19), and caregivers have been found to be above the threshold for clinically significant stress related to caring for their children(20). The economic cost of FASD has been estimated at several billion dollars per year in the United States(21).

Cognitive and behavioural interventions for children with FASD have been shown to improve self-regulation, attention and social skills, and interventions for caregivers have shown promising initial evidence of improving parenting efficacy and knowledge of FASD(22). Early diagnosis and support is a protective factor that predicts improved educational attainment and a reduction in behavioural and social problems(23, 24). However FASD is frequently under-recognised due in part to limited knowledge and awareness among health professionals and inconsistent identification of alcohol-consumption in pregnancy(25). Moreover, there is a lack of services to support women with problematic alcohol use, despite strong evidence supporting the effectiveness of appropriate interventions(25).

Alcohol-exposed pregnancies can be prevented by more stringent regulation of the alcohol industry (especially with regard to labelling), interventions designed to reduce alcohol consumption(26), improved training and care provision in maternity services targeted towards drinking cessation or risk reduction, promotion of global awareness of the risks of alcohol use in pregnancy, and increase in effective use of contraception(27-29).

FASD is a major international public health concern with emerging evidence of effective interventions, however the most effective intervention of all is to try to prevent the disorder by reducing levels of alcohol consumption in pregnancy. We strongly recommend that the WHO acknowledges the scale of this issue and include recommendations for FASD prevention and mitigation policies in their global strategy to reduce the harms associated with alcohol use. The WHO strategy should include a recognition of this widespread, avoidable and often hidden harm. Through

the strategy, member states should be encouraged and supported to introduce a wide variety of public health measures targeted at reducing the levels of avoidable harm caused by alcohol consumption in pregnancy and monitor and evaluate the progress made.

With best wishes

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UK Government

Department/Unit: *Department of Health and Social Care*

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

Submission

This is a submission by the Department of Health and Social Care (DHSC) on behalf of the UK Government, the Devolved Administrations (excluding Scotland), HM Treasury, Public Health England, the Home Office and the Ministry of Justice.

Attachment(s): 1

00349_22_who-consultation-final.pdf

UK Government comments on the working document for development of an action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

Introduction

This is a submission by the Department of Health and Social Care (DHSC) on behalf of the UK Government, the Devolved Administrations (excluding Scotland), HM Treasury, Public Health England, the Home Office and the Ministry of Justice.

We appreciate the opportunity to respond to the consultation to support the Global Strategy to Reduce the Harmful Use of Alcohol (the strategy). Due to the limited time for the consultation we could not engage with the detail as much as we would have wanted.

The UK Government values the opportunity to contribute to the development of the action plan. The UK Government are in broad agreement with the working document; however, we have some additional considerations that we believe would greatly strengthen the Strategy's ability to reduce the harm caused by alcohol.

We have set out an annex A a summary of our policies particularly in relation to reducing health harms associated with alcohol consumption in England. Different policies are being pursued in the devolved administrations in Scotland, Wales and Northern Ireland.

The WHO's vision in the Global Strategy is not wholly reflected in the indicators

The vision behind the 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"*.

Adopting a broader measurement of morbidity or mortality in the WHO target indicators would be advantageous, and is possible using metrics such as ICD10 codes, whereby conditions that are either partially or wholly attributable to alcohol can be reported, such as alcoholic liver disease. Changes in these indicators of alcohol-related harm should then be used to measure the progress of WHO Member States.

Greater clarity over the most effective and cost-effective approaches

The WHO endorses the 10 action areas listed in the strategy, three 'best buys' in alcohol policy, and more recently, five areas of focus in the SAFER framework. UK Government agrees that the most effective approach to reducing alcohol consumption and harm is one that combines a comprehensive mix of policies. However, given there is currently a lack of clarity around the actions and policies that should be prioritised. We therefore consider the strategy would benefit from clearer priority setting.

Improve WHO communication with non-health stakeholders and ensure WHO publications speak to these stakeholders

Currently, the WHO strategy is centred on health, and largely communicates with health stakeholders, many of whom having been working towards implementing policies and interventions set out in the strategy since its inception. A broader approach that considers a broader range of Government decision makers including those who lead on taxation policies would be welcomed. For example, if the WHO could lead on the development of a tool that would be useful with decision-makers which estimates the economic cost of inaction, for example deaths averted, cost to the health service and cost to the economy.

Trade and the negotiation of trade deals is an increasingly important consideration for policymakers when planning alcohol control policies. It is important to ensure that policies on trade and health do not undermine each other.

There is a failure to recognise the broad socio-economic impacts of alcohol

The broad socio-economic impacts of alcohol remain insufficiently recognised. Alcohol harms are not experienced equally across groups, with people of lower socioeconomic status showing greater susceptibility to alcohol harms and having a higher likelihood of dying or suffering from a disease relating to their alcohol use. For the English population, rates of alcohol-specific and related mortality increase as deprivation levels increase and alcohol-related liver disease is strongly related to socioeconomic gradient. This is paradoxical as lower socioeconomic groups often report lower levels of average consumption yet experience similar or greater levels of alcohol-related harm, known as 'the harm paradox'. Strategies aiming to reduce alcohol-related harms would be improved by acknowledging this 'harm paradox' and its implications for policies and interventions. Though the strategy's vision is to reduce harm, it must go further and commit to reducing harm alongside reducing health inequalities.

Synergies at the clinical, behavioural and policy level

Currently, the commercial determinants of health (alcohol, poor diet etc) are the leading causes of ill-health, disability and death. 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. Rather than duplicating efforts by working in a single health/policy area, especially with these strong behavioural, clinical, and policy synergies, this strategy may benefit from promoting an integrated approach across all action areas, particularly Action Areas 1-3 (high-impact strategies, national policy, and partnerships/coordination).

Additional comments on indicators

In addition to the high-level comments set out above, we have some additional comments that are specific to each of the actions and global targets listed in the working document as follows.

WHO targets and indicators – general comments

Where targets are directional, for example, “1.2 *At least x% relative reduction in alcohol per capita (15 years and older) consumption achieved by 2025 and x% relative reduction by 2030*”, there needs to be clarity relating to the baseline – how this was chosen and how it will be measured, using what data. Additionally, where progress targets have been set, it is not clear how these were chosen. Justification for the level of change, and the dates the target wishes to be reached by is required. Some indicators seem to have already been achieved, or are very close to being achieved, for the EURO region, for example, 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”*. It may therefore be appropriate to consider separate, more ambitious targets, for each WHO EURO region, based on the available data.

If the alcohol policy index scores are to be used to measure indicators such as “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*” then we suggest adjustments to the current score calculation. This is since, currently, the scores do not take into account enforcement, rather the presence or absence of a policy.

Most indicators require data collection from existing sources, some of which are not regularly updated, including the WHO Global Survey on Alcohol and Health which runs roughly every four years. To ensure up-to-date monitoring and reporting, we suggest increasing the regularity by which this data is collected.

Consideration needs to be given to whether per capita consumption is the most appropriate measure or per capita consumption per drinker. In recent years there have been increasing numbers of abstainers in European countries, as such, per capita measurements may perhaps be artificially deflated, even if drinking among older people remains unchanged. Indeed, focusing on and reporting change in segments of the population known to experience the greatest harm, such as higher risk drinkers, may be useful.

Annex A

UK policies to tackle alcohol harm in England

The UK Government has an existing agenda on tackling health harms from alcohol and we are committed to supporting the most vulnerable at risk from alcohol misuse. We are seeing an overall decrease in the amount of people drinking, especially from the younger population, which is highly encouraging. We are happy to share our learning and engagement at an international level.

Over the past decade we have taken multifaceted approach to tackling health harms from alcohol. This has been achieved through local and national strategies (alcohol strategy published in 2012), licensing laws, drink driving laws, taxation system, public education, public health provisions to treat addiction and providing health care services, incentive schemes in the NHS to identify those at risk from drinking, advertising standards and codes for industry to abide and communicating risk on alcohol labelling.

Alcohol consumption in the UK

Alcohol consumption is regularly monitored in the United Kingdom, by public health bodies, the private sector and third sector organisations. The Office of National Statistics publishes reports on adult drinking habits in Great Britain.

There has been an overall decrease in consumption over the past decade and an increase in teetotalism especially among the younger population. We outline policy areas that DHSC is implementing to further reduce harmful alcohol consumption.

Increase the availability of Low and No alcohol products

The Prevention Green Paper “*advancing our health: prevention in the 2020s*” was published in July 2019 and focuses on prevention of ill health. The paper made a specific commitment to increase the general drinking population towards lower strength alternatives to moderate drinking habits, and to support further innovation in the sector. Two specific actions include:

- To work with industry to deliver a significant increase in the availability of alcohol free and low alcohol products by 2025.

- Review the evidence to consider increasing the 0.05% abv alcohol threshold to 0.5% in line with other European countries.

DHSC is to co-host a roundtable in January 2021 with the Portman Group to discuss proposals to meet the 2025 objective. This policy area has received extensive engagement from the alcohol industry.

The Chief Medical Officers' Guidelines

We continue to produce the evidence base of health harms from alcohol and monitor alcohol use. In 2016 the UK Chief Medical Officers' low risk drinking guidelines provide the public with the most up to date scientific information so that they can help people make informed decisions about their own drinking the guidelines were changed to a weekly, rather than daily, limit and lowered to 14 units per week for men and women. The guidelines give clear advice to avoid alcohol completely during pregnancy.

Increase awareness among the general population

The UK government is in agreement that the general public have a right to accurate information and clear advice about alcohol and its health risks. The Government has worked with the alcohol industry to ensure that alcohol labels reflect the United Kingdom Chief Medical Officer's Low Risk Drinking Guidelines for drinks produced after 1 September 2019. The industry has committed to comply with this requirement. This ensures consumers have the best available information at point of purchase/consumption.

To combat obesity the UK Government published a new Obesity Strategy in July 2020 in which we will consult on the intention to make companies provide calorie labelling on all pre-packaged alcohol they sell, so when consumers shop for alcohol, they have all the information they need to make healthier choices. The consultation will also cover introducing calorie labelling on alcoholic drinks sold in the out of home sector, for example bought on draught or by the glass, as we have done with our measures on food and non-alcoholic drink outlined above.

The UK Government is in agreement that appropriate attention should be given to preventing the initiation of drinking among children and adolescents. The Government is committed to working with industry to address concerns over any irresponsible promotions, advertising and marketing relating to alcohol, particularly to ensure that children and young people are suitably

protected. Material in the Committee of Advertising Practice and Broadcast Committee of Advertising Practice Codes relating to the advertising and marketing of alcohol products is exceptionally robust, recognising the social imperative of ensuring that alcohol advertising is responsible and in particular that children and young people are suitably protected. If new evidence emerges that clearly highlights major problems with the existing Codes, then the Advertising Standards Authority has a duty to revisit the Codes and take appropriate action.

National programmes to support the most vulnerable in society

The UK does not currently have an alcohol strategy but the most vulnerable in society are supported by national programmes and the NHS Long Term Plan.

Children of Alcohol Dependent Parents programme

DHSC are working with the Department of Work and Pensions (DWP) have invested £6m on a jointly funded package of measures, over three years (2018-21), to improve outcomes and support for children whose parents are alcohol dependent.

This includes £4.5m for local authority innovation fund, funding for voluntary sector organisations. The innovation fund grants is successfully allowing 9 areas across England to build a systemic focus on improving their response to vulnerable families – reducing the use of expensive child protection resources, building the ability of parents to conflict in their relationships, and successfully treating alcohol dependence and children's trauma as part of a wholistic family intervention. A further £1m Section 64 funding is allocated to voluntary organisation to help build capacity to help us better identify and support children, and tackle conflict within families. to develop new resources and training and additional helpline and contact services for children. A further 5 voluntary organisations are funded as part of the Children of Alcohol Dependent Parents programme (CADEP) to support grassroots initiatives to prevent cases of Foetal Alcohol Spectrum Disorder and help improve support for those living with its consequences.

NHS Long Term Plan Alcohol Care Teams

The NHS Long Term Plan was published in 2019 and one of its commitments was to roll out Alcohol Care Teams (ACTs). There are population groups who continue to drink at harmful levels, which is strongly correlated with health inequalities and we are determined to do more to support the most vulnerable or at risk from alcohol misuse. As part of the NHS Long Term Plan (LTP), we are supporting acute hospitals to establish or improve specialist ACTs in

hospitals with highest rates of alcohol harm. It is estimated that, if implemented in the 25% of hospitals with the highest rates of alcohol-dependence-related admissions, fully optimised ACTs could prevent 50,000 admissions over 5 years. Identifying alcohol dependent patients and starting treatment for dependence in hospital and supporting transfer to community alcohol treatment services, on discharge, leads to recovery and reduces risk of adverse health outcomes. Existing ACTs in Bolton, Salford, Nottingham, Liverpool, London and Portsmouth have already seen a reduction in A&E attendances and alcohol-dependence related readmissions.

Addiction Strategy

The UK Government is aiming to publish a new UK-wide cross-government addiction strategy which will include alcohol although work on this is currently paused due to the covid-19 pandemic. The strategy will also be informed by Dame Carol's Black's ongoing review of drugs, part two of which focuses on prevention, treatment and recovery.

Home Office contribution

To tackle alcohol-related crime, we are delivering an innovative programme of alcohol abstinence monitoring, beginning with rolling out court-imposed Alcohol Abstinence Monitoring Requirements across England and Wales, and considering options for alcohol monitoring on license and using out of court disposals. We are also increasing the availability and usage of Alcohol Treatment Requirements for community sentences. Work to improve the response to alcohol in relation to domestic abuse has been undertaken. The Government keeps the licensing regime under review and is driving forward legislative work to enable the widespread use of digital ID for age-restricted products.

During the Covid-19 pandemic, we have temporarily modified the Licensing Act 2003 to provide an automatic extension to the terms of on-sales alcohol licences to allow the sale of alcohol for consumption off the premises and suspend more restrictive conditions on existing off-sales licences. Minimising the implications of the COVID-19 pandemic is a priority for teams across Government, including those working on tackling alcohol-related harms.

HM Treasury

HM Treasury (HMT) are carrying out a review of alcohol duty. HMT is not in agreement to a direction of travel that seeks to put alcohol on the same footing as tobacco. Particularly the mooted suggestion of creating a FCTC-equivalent for alcohol, as this would be unviable.

HMT further commented on the action points in section 6:

- Global target 6.1: 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: 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.

This would not be supported in any way. It's antithetical to HMT to hypothecate taxes, and we would say that resourcing of alcohol prevention/treatment is a matter for member states in line with their national circumstances and not something to be determined by WHO targets.

Unibersity of The Basque Country

Department/Unit: *Faculty of Labour Relations and Social Work*

Country/Location: Spain

URL: <https://www.ehu.eus/es/web/lan-harreman-gizarte-langintza-fakultatea>

Submission

1. Necesitamos de estudios contundentes que permitan establecer la relación no solo entre el alcohol y las consecuencias de su uso indebido, sino también entre este uso y factores emocionales y de salud mental. Los niveles de estrés sociales, familiares, urbanísticos, laborales, etc., las desigualdades sociales, económicas, culturales, convierten al alcohol en el fármaco que permite sobrevivir dentro de la no sostenibilidad social del sistema al que hemos llegado.

2. Creemos que es importante incluir el concepto de sostenibilidad social, en las medidas que se vayan a incluir.

Esta medida puede, a su vez, controlar que el uso del alcohol no siempre tenga que ser sustituido por el uso del fármaco. Proponemos una lectura de las estrategias para el alcohol desde los conceptos de sostenibilidad, tan aceptados y difundidos entre la población mundial, puede tener una lectura más comprensible y una respuesta más eficaz. Introduzcamos este uso indebido del alcohol entre los indicadores de sostenibilidad social. Reforcemos el concepto de sostenibilidad social...

3. Teniendo en cuenta que las políticas indudablemente tienen que ser locales, es difícil que estas dispongan de los medios necesarios si no se integran en programas más globales. Las políticas globales han de poder integrar diferencias, modelos de actuación diversos, permitiendo salirse de sus propios límites y barreras para la participación...

4. En nuestras investigaciones y estudios sobre el alcohol, buscamos lo común, lo que le pasa a la mayoría, sin embargo, proponemos pasar a pensar en lo pequeño, lo que nos diferencia, lo excepcional, a través de más estudios comparativos que den valor a las diferencias... Lo raro nos puede alejar de discursos globales y pomposos, y la suma de lo raro ayudarnos a dar con respuestas nuevas. Habría que reforzar el seguimiento en los procesos no logrados.

5. Replantearse el papel de la Comunidad y el desarrollo comunitario como recurso y herramienta para lograr los objetivos. Propuestas que puedan ser pensadas, desarrolladas y evaluadas por las mismas comunidades, barrios, pueblos, etc., dando protagonismo a las propias personas usuarias, haría mella directa en el empoderamiento directo de las personas y de las comunidades en las que vive. Mejorar los procesos de participación en la gestión y gobernanza de las políticas dirigidas a reducción de la oferta y la demanda del uso indebido de alcohol.

Proponemos que el proceso finalice en la comunidad, que vaya de la persona consumidora, al sistema que forma con su terapeuta, al que forma con el grupo de consumidores y consumidoras, al que forma con la comunidad de vecinos, del barrio, del pueblo, en el que participan bares, supermercados, Podemos establecer mecanismos de protección entre todos y todas... en los que todos y todas formamos parte del cuerpo de salud... No sólo vamos a aprender a separar la basura, también a cuidarnos de las personas con las que convivimos.

Revisemos a su vez el concepto de comunitario con el que nos manejamos en estos documentos.

Attachment(s): 0

Union for International Cancer Control

Country/Location: Switzerland

URL: www.uicc.org

Submission

Please see document attached.

Attachment(s): 1

00391_44_uicc-submission-who-working-document-action-plan-in-support-of-the-who-global-strategy-to-reduce-the-harmful-use-of-alcohol.pdf

Many thanks for the opportunity to submit this feedback on behalf of the Union for International Cancer Control (UICC). The working document is a timely and welcome development given the continuing rise in alcohol consumption and corresponding burden of alcohol-associated cancers, and particularly in light of the rise in use of alcohol associated with the COVID-19 pandemic and control measures¹. Our concern is that this increased use of alcohol will not only increase the burden of alcohol-related cancers, but may also diminish the implementation of effective, evidence-based alcohol policies.

The comments below represent UICC's perspectives on the 14th November working document and integrates comments and examples of national work and/or organisational resources shared by UICC members. This review has been divided up into five sections to facilitate easier engagement with the feedback and any questions regarding the comments below should be directed to the UICC Advocacy Team (advocacy@uicc.org).

We thank the WHO again for the opportunity to contribute to this process and hope to support the WHO team in the development of a robust action plan over the coming year.

1. Challenges and hurdles to global strategy implementation

The challenges and hurdles faced by the cancer community in engaging in national discussions and supporting implementation of alcohol control measures are multifaceted but some of the key areas are:

- **Misinformation and misunderstanding of the dose-risk relationship between alcohol consumption and cancer.** There persists a base level of misunderstanding about the risk that alcohol poses to individuals cancer risk² which reduces public demand for change and the effectiveness of alcohol prevention strategies. In addition, we have seen the use of studies on alcohol risk from other health areas to argue for diminished risk or some protective effect from alcohol consumption, weakening the case for national action.
- **Limited national capacities to implement evidence-based alcohol control measures,** such as the SAFER package. Feedback from UICC members, particularly in low- and middle-income countries, echoes findings from the WHO Global Status report on alcohol and cancer that the limited and uneven implementation of the SAFER package is in part the result of limited national capacity. In particular, Governments are facing significant political and legal challenges when pursuing fiscal measures such as raising excise taxes or minimum unit pricing.
- **Inability of national regulations or policies to keep up with developments** for example the increasing marketing of alcohol to young adults and children, particularly using online and native advertising.³
- **Complexity in the production, distribution, sale, and consumption of alcohol** has increased the difficulty in implementing and enforcing policies. For example, Canada has a mixed model with multiple actors and priorities including privatised, privatised-public, and public monopolies on alcohol sales and distribution across different provinces.

¹ Canadian Centre on Substance Use and Addiction. 25% of Canadians are drinking more while at home due to COVID-19 pandemic; cite lack of regular schedule, stress and boredom as main factors. April 2020: <https://www.ccsa.ca/sites/default/files/2020-04/CCSA-NANOS-Alcohol-Consumption-During-COVID-19-Report-2020-en.pdf>

² World Cancer Day International Public Opinion Survey on Cancer, February 2020. <https://www.worldcancerday.org/PublicOpinion>

³ Lack of regulation leaves door open to harmful digital marketing of alcohol, July 2020: <https://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/news/news/2020/07/lack-of-regulation-leaves-door-open-to-harmful-digital-marketing-of-alcohol>

- **The engagement of the alcohol industry in research and funding for studies and lobbying.**
The creation of industry-supported bodies like the International Alliance for Responsible Drinking (IARD) can further muddy the waters in terms of public and policy maker understanding of the risks, and numerous UICC members have examples of industry interference to weaken or stop evidence-based alcohol control measures. In particular, there has been a strong focus by these groups and the alcohol industry on self-regulation, despite the absence of robust data on its effectiveness.

2. Comments on the framing (aims and objectives etc.) of the working document

UICC welcomes the scope and ambition of the document to provide guidance, set priorities for global action and develop a portfolio of policy options as there is a clear and urgent need to scale-up the implementation of the global strategy. It is also useful to have:

- Action areas which clarify the roles and expectations of different partners
- Guiding principles (Box 5) relating to alcohol policies are important goals for Member States to strive for.

In order to further enhance the clarity and readiness of the action plan to support implementation, UICC wishes to share the following suggestions to:

- Clarify the language used around the action plan general objectives and operational objectives to foster better understanding of their purposes and how they are mutually supportive
- Set out the relationships between the key elements of the Global Strategy, the working document and the SAFER package to better understand how each of the elements will contribute to a more effective global, regional and national response (e.g. Global strategy sets out the goals, action plan provides a framework or roadmap for action, and the SAFER package a menu of evidence-based policy options)

3. Document strengths

There are several areas in the document which are valuable and will contribute to a stronger action plan, including:

- **Outline of the lack of progress to date and challenges** to provide context for the action plan, demonstrate the need for urgent action and provide a framework to check the relevance of the proposed activities.
- **Six action areas** and the explanation behind the, including the delineation by group in order to clarify the roles and expectations.
- **Linkages with the SAFER package** and recognition of the potential need to adapt or refine global packages to respond to regional contexts as it could allow for policy development to push effective policy and monitoring practices (in line with the aims of the document and SAFER initiative).
- **Inclusion of evidence outlining effectiveness and cost-effectiveness of alcohol control measures** is valuable information for member states in communicating cost-benefit arguments to decision-makers.

4. Potential areas to strengthen

The working document provides a robust starting point for development. To help strengthen the document further UICC would suggest the following areas for consideration:

- **Utilise data on the dose-risk relationship between alcohol and cancer to support comprehensive action** and to counter lobbying industry-backed organisations to weaken alcohol control measures by focusing conversation on associations for which the evidence is less clear and robust. The consumption of alcoholic beverages is classified as a carcinogen with strong causal

evidence between alcohol and cancers of the oropharynx, larynx, oesophagus, liver, breast, colon and rectum.^{4,5}

- Recognising the audience groups are varied for such a document, more statistics and attention to cancers caused from alcohol could be included to strengthen the case for action while further evidence is gathered across other health areas.
- Understanding the fluidity of the situation, greater focus could be paid to **alcohol consumption and policy changes during the COVID-19 pandemic**. As more data become available, hypotheses could be offered regarding the influence of policy and consumption changes on non-communicable diseases and other harms due to the pandemic.^{6,7}
- **Further exploration and utilisation of the investment case underpinning comprehensive alcohol measures**, utilising existing data and tools from WHO (including the different costing tools) to support the prioritisation of different policy measures, particularly focusing on the integration of the SAFER package into relevant national and regional strategies on health, trade etc.
- **Establishment of a platform to coordinate stakeholder work** recognising that stakeholders have diverse expertise, capacities and resources and that stakeholders should be subject to clear and robust conflict of interest scrutiny. It would therefore be valuable to learn from existing WHO and other mechanisms to best utilise the resources represented by these groups to avoid the duplication of work. One model could be along the lines of the International Cancer Control Partnership which coordinates partner resources and time to support Member States in comprehensive cancer control planning with WHO counted as one of the key members.
 - Nationally, we would encourage the Secretariat to **consider existing coordination models** for example national cancer control committees to coordinate national stakeholders in the development, implementation, and evaluation of plans in order to maximise engagement with plans, leverage advocacy capacities to build support, utilise non-government resources to support implementation, and provide a mechanism for communities and people affected by alcohol use to share their experiences.
 - Within this stream of work, it would be valuable to **support civil society engagement** national mechanisms, at the same time recognising that smaller CSOs may require training and support to succeed in this role.
- **Put in place robust mechanisms to avoid conflicts of interest with alcohol producers, distributors and retailers globally and recommend similar actions regionally and nationally** as part of government responses. UICC recognises that the current political impact of the alcohol industry (inclusive of distributors and retailers) is such that it is impractical to pursue a tobacco-like stance prohibiting alcohol for participating in global, regional and national discussions on alcohol control. However, UICC would urge the WHO to put in place and recommend robust conflict of interest protections in line with existing commitments in the 2010 Global Strategy and UN High-level political declaration on NCDs including:
 - Clearly defining the aims and objectives of engaging with the alcohol industry in order to prevent industry actors from using this engagement to 'whitewash' their reputations.
 - Defines the 'value-add' or impact of these discussions or dialogues and ensures absolute transparency where WHO engages
 - Making all the outcomes of these discussions or dialogues available to the public with clear reporting on actions taken by both sides to implement these outcomes and the impact this is having on advancing action against the global alcohol targets.

⁴ World Cancer Report (chapter 2.3), February 2020: https://www.iarc.fr/cards_page/world-cancer-report/

⁵ Connor, J. (2016). Alcohol consumption as a cause of cancer. *Addiction*. doi:10.1111/add.13477.

⁶ Hobin, E., Smith, B. Is another public health crisis brewing beneath the COVID-19 pandemic?. *Can J Public Health* 111, 392–396 (2020). <https://doi.org/10.17269/s41997-020-00360-z>

⁷ Lange, S., Probst, C. & Rehm, J. Coronavirus disease 2019 crisis and intentional injuries: now is not the time to erode alcohol control policies. *Can J Public Health* 111, 466–468 (2020). <https://doi.org/10.17269/s41997-020-00391-6>

- Holds all actors to account for their commitments through regular reporting as part of global reports on alcohol progress.
- This will be important to help safeguard WHO's reputation as guardian of global public health and help define models of engagement that Member States can utilise regionally or nationally.
- **Develop clear timelines and goals through to 2025 and 2030**, corresponding with key points in the global NCD response to connect and align mutually supportive actions.
- **Refine global targets to support national progress**. For example, establish baselines from existing data to monitor progress in the number and populations covered national plans which have budgets and adequate resources as a percentage of national needs. These data would to accompany higher-level statistics around global resources for alcohol control to produce a clearer understanding of how global needs are being met, as well as changes to support Government decision making and prioritisation when it comes to national vs. international resource use. This could utilise existing WHO costing tools and resources but should be focused on tracking national progress against national baselines and not necessarily cross-comparing countries.
- **Strengthen the identification and alignment with other relevant global action plans** such as those on mental health or non-communicable diseases.
- **Include regional or national case studies** as a guide to practical implementation of an alcohol action plan, enabling national, regional/county and city decision makers to learn from other who are further ahead in implementation, providing a resource and model for other Member States to follow.
 - **Pay greater attention to methods and sensitivities when working with varied or vulnerable populations**. Different populations require different approaches, policies, and messaging - outlining such differences would prove helpful and could draw on existing resources.

5. Other comments

UICC wishes to commend the Secretariat for the development of the current working document. The comments below are reflections on how the cancer community may be able to support the Secretariat in their work with Member States nationally and regionally, as there is a clear need for technical assistance in prioritising and developing national and regional alcohol control. This is recognised both the 2018 Global Status report and the current working document, and UICC urges the Secretariat to make this a central part of their response including by:

- More systematically engaging and coordinate with non-governmental actors to support work globally and regionally, for example:
 - [McCabe Centre for Law and Cancer's legal training programmes](#)
 - [Canadian Partnership Against Cancer's alcohol policy pack](#) which includes Canadian studies and context for alcohol policy
 - [World Cancer Research Fund International's data collection and assessment](#)
- Supporting Member States to review and improve national strategies on alcohol control, or which contain alcohol control measures, to ensure that they provide a strong foundation for action (for example, is there a budget, is there an oversight mechanism, how are stakeholders engaged, what measures are in place to avoid conflict of interest). Tools exist across WHO which could be adapted or repurposed to help with these assessments and in turn these documents provide a ready framework around which national actors can be brought it and partnerships developed to accelerate nationally implementation.
- Setting the tone for cooperation on alcohol control by establishing a global mechanism to keep track of available resources and data, coordinate technical and other forms of support and minimise and respond to conflicts of interest. WHO has a clear normative role and could help develop best practices for this through their own approaches.

December 9, 2020

Attn: Ms. Rosie Tasker
Global Advocacy Manager
Union for International Cancer Control (UICC)
31-33 Avenue Giuseppe Motta
1202 Geneva – Switzerland
tasker@uicc.org

RE: Consultation: WHO Global Alcohol Action Plan

Dear Ms. Tasker,

As a member organization of the Union for International Cancer Control (UICC), the Canadian Partnership Against Cancer (CPAC) is pleased to contribute a response to the WHO Global Alcohol Action Plan Working Document. If you have any questions pertaining to our submission, please contact Michelle Halligan, Director of Prevention, at michelle.halligan@partnershipagainstcancer.ca. Thank you for including us in this important work.

Input below is in response to the working document found here: [Towards an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol \(who.int\)](#)

1. What are the challenges/hurdles to implementing the global strategy in your country?

There are several hurdles specific to Canada that have challenged progress in this area. First, the alcohol system of production, sales, distribution, and consumption within Canada is complex with multiple actors and priorities. A mixed model of privatized, privatized-public, and public monopolies of alcohol sales and distribution exists across Canadian provinces which adds complexity to introducing and enforcing policies.

Further, previous efforts to limit alcohol sales and tighten alcohol policies for public health reasons have been met with strong industry lobbying; with weakened impact as a result.

Additionally, alcohol consumption continues to rise in Canada, due in part to lack of public awareness of cancer and other health risks, along with increased access, marketing, and availability of alcohol products.¹ The COVID-19 pandemic has only complicated this issue, marrying increased consumption with loosened alcohol policies.²

As uncovered by CPAC's analysis of Canadian policies via [CPAC's Alcohol Policy Pack](#); there is incomplete and inconsistent adoption and implementation of evidence-informed alcohol policies that would support reductions in alcohol consumption across Canada.

¹ Giesbrecht, N, Wettlaufer, A, April, N, Asbridge, M, Cukier, S, Mann, R, McAllister, J, Murie, A, Plamondon, L, Stockwell, T, Thomas, G, Thompson, K, and Vallance, K. (2013). Strategies to reduce alcohol-related harms and costs in Canada: A comparison of provincial policies. Toronto: Centre for Addiction and Mental Health.

² Canadian Centre on Substance Use and Addiction. 25% of Canadians are drinking more while at home due to COVID-19 pandemic; cite lack of regular schedule, stress and boredom as main factors. April 2020: <https://www.ccsa.ca/sites/default/files/2020-04/CCSA-NANOS-Alcohol-Consumption-During-COVID-19-Report-2020-en.pdf>

2. Do you agree with the purpose and aims of the document?

CPAC supports efforts to implement effective policies that will lead to reductions in alcohol consumption and cancer risk in Canada. Implementing evidence-informed policies and other protective factors, as found within the Global Alcohol Action Plan, will support reductions in alcohol consumption and cancer risk, both in Canada, and globally. CPAC agrees with the purpose of the document with the suggestion to include the concept of *population health* within the purpose statement (e.g. ... complement public AND POPULATION health policies ...):

Purpose: to support and complement public health policies in Member States, including national and local efforts.

CPAC agrees with the aims of the document as stated below:

Aims: to give guidance for actions at all levels; to set priority areas for global action; and to recommend 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.

3. Do you find the document accessible and easy to understand?

CPAC supports efforts to implement effective policies that will lead to reductions in alcohol consumption and cancer risk in Canada. The document follows a logical progression through setting the scene, outlining goals and scope, and describing action areas for solutions. The included appendices are helpful to achieve a deeper understanding of WHO's contribution to this work. Publishing the final document according to accessibility guidelines and across a variety of mediums, such as HTML webpages, may increase accessibility among different populations and across multiple devices.

4. What do you think are the strengths of the document?

There are several strong points to this document. First, the six action areas are documented and explained well. Action areas delineated by group is also helpful to clarify roles and expectations.

Second, statistics outlining the lack of progress in reducing total global alcohol consumption per capita highlights the urgency of this work.

Third, the inclusion of guiding principles (seen in BOX 5) as they relate to alcohol policies are important goals for member states to strive for.

Additionally, description of the SAFER initiative is welcomed. If regionally implemented, this program could allow for policy development with a push to establish effective monitoring practices, as described within the aims of the program.

Lastly, inclusion of evidence outlining effectiveness and cost-effectiveness of alcohol control measures is valuable information for member states in communicating cost-benefit arguments to decision-makers.

5. Do you think anything is missing or needs greater focus?

CPAC supports efforts to implement effective policies that will lead to reductions in alcohol consumption and cancer risk in Canada. The consumption of alcoholic beverages is classified as a carcinogen with strong causal evidence between alcohol and cancers of the oropharynx, larynx, oesophagus, liver, breast, colon and rectum.³ Recognizing the audience groups are varied for such a document, more statistics and attention to cancers caused from alcohol could be included.

Understanding the fluidity of the situation, greater focus could be paid to alcohol consumption and policy changes during the COVID-19 pandemic. As more data become available, hypotheses could be offered regarding the influence of policy and consumption changes on non-communicable diseases and other harms due to the pandemic.^{4 5}

Alignment and further description of other relevant global action plans such as mental health or non-communicable diseases could be strengthened.

Inclusion of jurisdictional profiles or member state case studies could be included as a guide to practical implementation of an alcohol action plan. Jurisdictions further ahead in implementation can be a resource and model for other member states to follow.

More attention could be given to discussing methods and sensitivities when working with varied populations. Different populations require different approaches, policies, and messaging - outlining such differences would prove helpful.

6. Do you think anything is included that shouldn't be there?

The document appears comprehensive as presented. CPAC has no suggestions to remove any of the current content.

7. Any other comments?

Over the past decade, much scientific literature has been produced in this area with Canadian studies and context provided through [CPAC's Alcohol Policy Pack](#).

CPAC supports the development and implementation of a global alcohol action plan to strengthen political will and effective implementation from member states to comprehensively address harms caused from alcohol, including those of cancers. We would be pleased to be included in any future consultations or other appropriate mechanisms of support.

³ Connor, J. (2016). Alcohol consumption as a cause of cancer. *Addiction*. doi:10.1111/add.13477.

⁴ Hobin, E., Smith, B. Is another public health crisis brewing beneath the COVID-19 pandemic?. *Can J Public Health* 111, 392–396 (2020). <https://doi.org/10.17269/s41997-020-00360-z>

⁵ Lange, S., Probst, C. & Rehm, J. Coronavirus disease 2019 crisis and intentional injuries: now is not the time to erode alcohol control policies. *Can J Public Health* 111, 466–468 (2020). <https://doi.org/10.17269/s41997-020-00391-6>

United European Gastroenterology

Department/Unit: *Public Affairs*

Country/Location: Belgium

URL: <https://ueg.eu/>

Submission

With nearly 30% of deaths from gastrointestinal diseases directly attributed to alcohol, UEG is committed to raising political and public awareness of the alcohol-related harm and welcomes the development of an action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

Although the Global Strategy gives a strong mandate to WHO to strengthen action not only at global levels, but also at national and regional levels, it lacks specific actions directed to a regional political body, as the European Union or the WHO's Regional Office for Europe.

We would also like to stress that necessary interventions such as the restriction of aggressive marketing, advertising and promotion of alcohol consumption, as well as labelling of alcoholic beverages, can only be achieved through government-led regulatory approach, as voluntary commitments fail to deliver consistent results and real added value for public health.

Attachment(s): 1

00322_05_ueg-response-to-who-consultation-global-action-plan-on-alcohol-final.pdf

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Gastroenterology (UEG)
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December, 2020

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

United European Gastroenterology (UEG) is a professional non-profit organization combining all the leading European medical specialists and national societies focusing on digestive health. Our member societies represent more than 30,000 specialists from every field in gastroenterology. Together, we act as the united and trusted voice of European Gastroenterology, promoting science, research, education, and quality of care. We aim at reducing health inequalities across Europe and improving digestive health.

With nearly 30% of deaths from gastrointestinal diseases directly attributed to alcohol, UEG is committed to raising political and public awareness of the alcohol-related harm and welcomes the development of an action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

Europe is the region with the highest level of alcohol consumption in the world and, as a result, Europe bears the highest burden of ill health and premature death linked directly to alcohol. To address this endemic matter, tackling the harmful use of alcohol should be a key priority for the European countries.

Although the Global Strategy gives a strong mandate to WHO to strengthen action not only at global levels, but also at national and regional levels, it lacks specific actions directed to a regional political body, as the European Union or the WHO's Regional Office for Europe.

As it is crucial that new proposals and schemes to reduce alcohol consumption are taken at regional and national levels - this should be clearly reflected in the action plan. In this respect, WHO regional offices are important for technical support to Member States in areas like following trends in alcohol consumption, estimates of alcohol-related harm, and financial costs. Moreover, European level proposals would provide a strong impetus for the renewal of the EU's Alcohol Strategy and the implementation of national public health policies aimed at reducing alcohol consumption in the Member States.

We would also like to stress that necessary interventions such as the restriction of aggressive marketing, advertising and promotion of alcohol consumption, as well as labelling of alcoholic beverages, can only be achieved through government-led regulatory approach, as voluntary commitments fail to deliver consistent results and real added value for public health.

Furthermore, the current document lists the 'economic operators' as 'stakeholders' alongside public health actors. Granting economic operators such role is disproportionate as it would lead to impediments in the development of effective alcohol control policies that run counter to their commercial interests. Therefore, the alcohol industry should, instead, be addressed in a separate section with due regard to conflict of interest toward safeguarding public health.

Universidad del Bío-Bío

Department/Unit: *Departamento de Ciencias de la Rehabilitación en Salud*

Country/Location: Chile

URL: <http://webfacsa.ubiobio.cl/>

Submission

Intentamos resumir la revisión de la literatura y la investigación en los Trastornos del Espectro Alcohólico Fetal, para que desde la OMS se logre instaurar en la sociedad, la conciencia sobre el daño que el consumo de alcohol durante la gestación causa en el neurodesarrollo del niño, y que lo afectará de por vida a él y a su entorno.

Attachment(s): 1

00487_13_comentarios-y-sugerencias-universidad-del-bio-bio-chile.pdf

COMENTARIOS Y SUGERENCIAS AL DOCUMENTO DE TRABAJO

MSc. SLP. Yuri E. Vega-Rodríguez

Dpto. de Ciencias de la Rehabilitación en Salud

Facultad de Ciencias de la Salud y de los Alimentos

Universidad del Bío-Bío, Chillán, Chile.

Consideramos que se hace necesario exponer que el consumo de alcohol durante la gestación es nocivo para el neurodesarrollo del feto. El alcohol es un teratógeno y causa toxicidad en el desarrollo neuronal durante la gestación (Memo et al., 2013). Hay extensa evidencia de que no existe un consumo seguro de alcohol en la etapa gestacional, y por ello se debe evitar la exposición a este en el niño en desarrollo. La misma OMS en algunos de sus boletines evidencia el enorme daño que genera la exposición prenatal al alcohol en las sociedades, en la vida de las personas y de su entorno (WHO, 2011, 2017). La exposición prenatal al alcohol puede generar un espectro de daños en el neurodesarrollo denominados Trastornos del Espectro Alcohólico Fetal (TEAF) (FASD en inglés). El rango de alteraciones se encuentra tanto en la estructura del cerebro, como en las áreas de funcionamiento cognitivo, social, lingüístico, emocional, de aprendizaje, adaptativas, de conducta y físicas (Brown et al., 2019; Lange et al., 2017; Mattson et al., 2001; Reid et al., 2015). El TEAF es la mayor causa de Discapacidad Intelectual congénita que es absolutamente prevenible, evitando el consumo de alcohol durante el embarazo; esto implica un gran trabajo de los profesionales de atención primaria en la educación de las madres gestantes. Los efectos de la exposición prenatal al alcohol tienen implicaciones que son permanentes en los individuos, ellos cargarán con estas alteraciones de por vida, por lo tanto, el TEAF es costoso para la sociedad (Popova et al., 2014, 2016). Se estima que 630.000 niños nacen con TEAF a nivel global anualmente, aunque esto solo está basado en los estudios que son publicados (Brown et al., 2019; Lange et al., 2017) por ello la prevalencia pudiese ser mayor. Más allá del costo para la sociedad, y que es innegable, ya que estos individuos procuran desde la infancia temprana una evaluación e intervención multidisciplinar por especialistas en las diferentes dimensiones de desarrollo del ser humano (Vega-Rodríguez et al., 2020), estos niños, jóvenes y adultos, son incomprensidos puesto que hay un bajo diagnóstico por el contexto adverso de su desarrollo, no hay apoyo social ni emocional, sufren durante toda su vida y por ende su entorno cercano también sufre.

Intentamos resumir la revisión de la literatura y la investigación en el tema, para que desde la OMS se logre instaurar en la sociedad, la conciencia sobre el daño que el consumo de alcohol durante la gestación causa en el neurodesarrollo del niño, y que lo afectará de por vida a él y a su entorno.

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University of Exeter

Department/Unit: *Psychology, Cognition Group*

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

URL: https://psychology.exeter.ac.uk/staff/profile/index.php?web_id=Lee_Hogarth

Submission

The single most powerful risk factor for harmful (as opposed to moderate) drinking is the explicit belief that alcohol consumption helps mitigate adverse states (such as low mood, anxiety, pain etc.). In prospective studies, people who report the belief that drinking helps cope with adverse states have a 3.1 times greater chance of becoming alcohol dependent in the future, and a 3.45 increased chance of remaining alcohol dependent (as opposed to quitting) in the future (Crum et al. 2013). Furthermore, individuals who have experienced harm states (e.g. mental illness, abuse, trauma, rape, bullying, economic deprivation) are at risk of alcohol dependence, and this risk is mediated (nominally caused by) the belief that drinking helps cope with adverse states (Hogarth 2020). Finally, adolescent prevention programs (Conrod et al. 2013) and adult treatment programs (Kushner and Anker 2019) which undermine the belief that drinking helps cope with adverse states, provide a specific, effective and long lasting reduction in alcohol consumption in high risk individuals. The policy implications are that screening should take place to identify at risk individuals who report drinking to cope with adversity, and interventions seek to undermine this belief in order to reduce alcohol consumption in vulnerable groups.

References.

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Attachment(s): 0

University of York Transformative Research on Alcohol Policy and Science programme

Department/Unit: *TRAPS is the Transformative Research on Alcohol Policy and Science programme at the University of York and is directed by Prof. Jim McCambridge. TRAPS is funded by the Wellcome Trust and the University of York. This research group works on alcohol policy*

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

URL: <https://www.york.ac.uk/healthsciences/research/mental-health/projects/transformativeresearchalcoholindustrypolicyscience/>

Submission

The introductory content on the challenges of implementation of the global strategy makes clear the roles of major alcohol companies in interfering with public health policy making, particularly where it refers to “the influence of powerful commercial interests in policy-making and implementation” page 4. Whilst welcoming the need to counter “undue influences from commercial vested interests that undermine attainment of public health objectives” (page 16), there is a need to be clearer about the framing of the roles of economic operators and the various invitations to them made throughout the document. There is a danger that such content will continue to be used by interests that are hostile to public health to gain access to policy making. Particular attention is recommended to:

1. Operational objective 2 on page 9, which might go further to specifically exclude alcohol industry interference in multi-sectoral actions. Not to do so may offer further opportunities to delay implementation.
2. The reference to co-regulatory frameworks in action 3 should be reconsidered to avoid any suggestion of endorsing such approaches. The scientific evidence* is very clear that cross-sector partnerships with powerful commercial interests in alcohol is a key means of frustrating and delaying implementation.

These examples invite very careful consideration of the ways in which all content relating to alcohol industry actors is presented, bearing in mind the framing of roles in relation to policy is a key means of interference in public health policy making* and the limited impact of the global strategy to date. It is vital that such actors are everywhere given a different status to public health actors.

Attachment(s): 0

Value Health Africa

Department/Unit: *Non communicable disease*

Country/Location: Cameroon

URL: www.valuehealthafrica.org

Submission

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

Attachment(s): 1

00524_35_vaha-who-workingdoc-consultation.pdf

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

Value Health 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*.

Value Health Africa is Value Health Africa (VAHA) is a non-profit, whose mission is to add value to life by improving health and wellness in Cameroon. Our work is focused on reducing premature mortality from communicable and non-communicable diseases and fostering sexual and reproductive health, through strengthening access to primary health care, policy advocacy and research.

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.

Country/Location: Slovenia

Submission

It is a widespread popular belief that alcohol consumption is increasingly problematic. Further, the WHO has been issuing worrying and negative forecasts and projections of alcohol consumption in the future. However, the facts indicate that alcohol consumption has been declining over the past decades, not just in the EU as a whole, but also in Slovenia in particular.

In fact, the Slovene National Institute of Public Health (Nacionalni Inštitut za javno zdravje - NIJZ) findings that the average level of registered alcohol consumption in Slovenia in 2019 was 11.05 litres of pure alcohol per capita (NIJZ 2020). As such, Slovenia ranks 5th among the EU countries on registered alcohol consumption. However, it is important to highlight that Slovenia is observing a decreasing trend in both excessive and high-risk drinking, as well as observing an overall increasing trend of abstinence since 2001 (Tomšič 2014, 72). Moreover, a public survey conducted among Slovenian adults in the period 2002 - 2018 reports that most alcohol consumption indicators have decreased (Jeriček Klanšček 2019, 61).

In addition to registered alcohol consumption, Slovenia has extensive unregistered alcohol consumption, which originates from domestic alcohol production, cross-border shopping, smuggling, etc. When interpreting alcohol consumption trends, it is advisable to be cautious since trends in registered and unregistered alcohol consumption are not necessarily parallel or might even be opposite under certain circumstances (for example, reduced availability of alcohol from registered production is likely to increase the usage of unregistered alcohol). In Slovenia, as an example, NIJZ reports that the estimated level of unregistered alcohol consumption varied between 5 and 7 litres per capita in 2005, while in 1994 ranged between 7 and 8 litres per capita (Zorko and others 2014, 35-36).

Importantly from a national socio-economic perspective, consumption of unregistered alcohol is closely linked to high taxes, poverty, and corruption, as well as the price of alcohol in neighbouring countries. Demand for alcohol is rather inelastic and consumers might respond to price increase in various ways, from switching to illicit trade, buying cheaper products, home production, smuggling, etc. (Snowdon 2012, 4).

Slovenia ranks high among EU countries in the health consequences of alcohol consumption and the number of alcohol related deaths. However, on a positive note, the trend of hospitalisations related to alcohol consumption is falling (Zorko and others 2014, 18). Although the consumption of alcohol per capita in Slovenia is high, this does not necessarily harmfully reflect on society.

There is not enough compelling evidence that countries with more paternalistic public health policies enjoy better public health as a result. On the other hand, excessive regulation creates many problems and unnecessary costs. There is a strong connection between health and wealth. The pursuit of economic growth brings greater benefits to health than coercive measures, such as tax increase. Increasing taxes raise the cost of living, which hurts the poorest the most (Snowdon 2019, 9). Similar observations were previously made by WHO, acknowledging that there exists a close link between socioeconomic development and harmful alcohol consumption and that worldwide alcohol consumption

is lower in less wealthy societies. At the same time, it is the poorer societies who experience a disproportionately high level of alcohol-related harm (WHO 2010, 7). Government interference in the name of health is unjustified and inefficient. Hence, it should be left to individuals to be the judges of their own best interests.

Mortality due to causes wholly attributable to alcohol consumption in Slovenia is the highest among residents in the least developed municipalities and decreases with the rising development of those. According to NIJZ, there is a significant distinction between regions and alcohol-related deaths in Slovenia, with residents of eastern and south-eastern Slovenia being almost twice as likely to die from alcohol-related causes in comparison to the rest of the country, which might be related to differences in socioeconomic status (Zorko and others 2014, 69). Therefore, in conclusion, alcohol-related harm mostly originates from socioeconomic inequalities (Kovše and others 2012, 119).

Attachment(s): 1

00200_20_visio-institut-response-to-whos-global-strategy-to-reduce-the-harmful-use-of-alcohol.pdf

Response to WHO' s Global strategy to reduce the harmful use of alcohol

It is a widespread popular belief that alcohol consumption is increasingly problematic. Further, the WHO has been issuing worrying and negative forecasts and projections of alcohol consumption in the future. However, the facts indicate that alcohol consumption has been declining over the past decades, not just in the EU as a whole, but also in Slovenia in particular.

In fact, the Slovene National Institute of Public Health (Nacionalni Inštitut za javno zdravje - NIJZ) findings that the average level of registered alcohol consumption in Slovenia in 2019 ranges between 10.3 and 13.5 was 11.05 litres of pure alcohol per capita (NIJZ 2020). As such, Slovenia ranks 5th among the EU countries on registered alcohol consumption. However, it is important to highlight that Slovenia is [since when?] observing a decreasing trend in both excessive and high-risk drinking, as well as observing an overall increasing trend of abstinence since 2001 (Tomšič 2014, 72). Moreover, a public survey conducted among Slovenian adults in the period 2002 - 2018 reports that most alcohol consumption indicators have decreased (NIJZ 2014 Jeriček Klanšček 2019, 61, 12).

In addition to registered alcohol consumption, Slovenia has extensive unregistered alcohol consumption, which originates from domestic alcohol production, cross-border shopping, smuggling, etc. When interpreting alcohol consumption trends, it is advisable to be cautious since trends in registered and unregistered alcohol consumption are not necessarily parallel or might even be opposite under certain circumstances (for example, reduced availability of alcohol from registered production is likely to increase the usage of unregistered alcohol). In Slovenia, as an example, NIJZ reports that the estimated level of unregistered alcohol consumption varied between 5 and 7 litres per capita in 2005, while in 1994 ranged between 7 and 8 litres per capita (NIJZ Zorko and others 2014, 35-36).

Importantly from a national socio-economic perspective, consumption of unregistered alcohol is closely linked to high taxes, poverty, and corruption, as well as the price of alcohol in neighbouring countries. Demand for alcohol is rather inelastic and consumers might respond to price increase in various ways, from switching to illicit trade, buying cheaper products, home production, smuggling, etc. (Snowdon 2012, 4).

Slovenia ranks high among EU countries in the health consequences of alcohol consumption and the number of alcohol related deaths. However, on a positive note, the trend of hospitalisations related to alcohol consumption is falling (NIJZZorko and others 2014, 18). Although the consumption of alcohol per capita in Slovenia is high, this does not necessarily harmfully reflect on society.

There is not enough compelling evidence that countries with more paternalistic public health policies enjoy better public health as a result. On the other hand, excessive regulation creates many problems and unnecessary costs. There is a strong connection between health and wealth. The pursuit of economic growth brings greater benefits to health than coercive measures, such as tax increase. Increasing taxes raise the cost of living, which hurts the poorest the most (Snowdon 2019, 9). Similar observations were previously made by WHO, acknowledging that there exists a close link between socioeconomic development and harmful alcohol consumption and that worldwide alcohol consumption is lower in less wealthy societies. At the same time, it is the poorer societies who experience a disproportionately high level of alcohol-related harm (WHO 2010, 7). Government interference in the name of health is unjustified and inefficient. Hence, it should be left to individuals to be the judges of their own best interests.

Mortality due to causes wholly attributable to alcohol consumption in Slovenia is the highest among residents in the least developed municipalities and decreases with the rising development of those. According to NIJZ, there is a significant distinction between regions and alcohol-related deaths in Slovenia, with residents of eastern and south-eastern Slovenia being almost twice as likely to die from alcohol-related causes in comparison to the rest of the country, which might be related to differences in socioeconomic status (NIJZZorko and others 2014, 69). Therefore, in conclusion, alcohol-related harm mostly originates from socioeconomic inequalities (Kovše and others 2012, 119).

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VISUAL TEAF

Country/Location: Spain

URL: www.visualteaf.com

Submission

it is important to mention alcohol during pregnancy as one of the harms which must be addressed.

FASD could be added along with mental health, violence, road traffic injuries and infectious diseases.

Attachment(s): 1

00392_45_who-comments.pdf

Visual TEAF is a national non-profit association of families. It was originally the idea of a family with a member affected by fetal alcohol spectrum disorder, FASD. It is registered in the Spanish National Register of Associations, in Section 1, with the number 615310; and in the Municipal Census of Entities and Citizen Collectives of the City of Madrid, with the number 3433; and in the category of Health and Mutual Support, subcategory of Disability. Tax Identification Card (NIF) G88055033. Visual TEAF works to improve the quality of life of those affected by FASD and their families, raising their visibility and increasing awareness in society of the importance of avoiding alcohol consumption during pregnancy.

Why is so important to mention alcohol during pregnancy as one of the harms which must be addressed?

Alcohol use during pregnancy in the WHO European Region is the highest globally.



WHO European
Region FASD prevalence

The mission 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, FASD is a noncommunicable disease, a disability 100% avoidable, FASD has no cure, FASD has a high social cost for affected, families and society at large.

We suggest, on page 2, paragraph 1, it could be added the FASD along with mental health, violence, road traffic injuries and infectious diseases, prenatal exposure to alcohol is clearly a harmful alcohol use, the alcohol is a teratogen, has a serious impact on the developing fetus and must be properly informed and controlled, FASD is one of the most important broader impact of harmful alcohol use, FASD has significant social and economic losses and should be considered in policies to reduce harmful use of alcohol.

We considered that the document should include actions to increase health awareness in alcohol consumption during pregnancy and the serious risks arising.



Mercedes del Valle Díaz,
presidenta de VISUAL TEAF
www.visualteaf.com

Vital Strategies

Country/Location: United States of America

URL: <https://www.vitalstrategies.org>

Submission

In response to WHO's working document for the development of an action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol, Vital Strategies would urge Member States and WHO to consider the following:

- i) The Role of the Industry;
- ii) Consistent Reporting on Implementation;
- iii) Emphasis on SAFER and Best Buys
- iv) Reexamine Subsidies to the Alcohol Industry

Attachment(s): 1

00292_59_statement-vital-strategies.pdf



Vital Strategies Statement regarding WHO consultation on the development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

10 December 2020

In response to WHO's working document for the development of an action plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol, Vital Strategies would urge Member States and WHO to consider the following:

1. Role of Industry

The working document lists "economic operators" or the alcohol industry as equal stakeholders along with civil society and UN agencies. Including the alcohol industry constitutes a clear conflict of interest due to its history of undermining effective alcohol control policies, especially in low- and middle-income countries (LMICs). "Economic operators" should be addressed separately to safeguard public health. That they produce a product that is harmful to health and push for ineffective voluntary guidelines for that product should be considered where policy issues are concerned.

2. Consistent Reporting on Implementation

The Action Plan currently does not mention the time period for review and reporting on implementation. Vital Strategies recommends that the Director-General should report on the progress of implementing the Global Action Plan at the World Health Assembly semi-annually. Reportage should include challenges faced by Member States and progress on collaboration between UN agencies.

3. Emphasis on SAFER and Best Buys

The numerous and sometimes overlapping recommendations in the draft document 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:

l) 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.

Further, monitoring indicators should include specific criteria for SAFER implementation and countries reporting on implementation should be encouraged and supported.

4. Reexamine Subsidies to the Alcohol Industry

Many governments and development agencies give significant economic incentives to the alcohol industry despite, products that create a growing health burden. In a forthcoming report, Vital Strategies documents the types and amounts of incentives going to the alcohol industry.

We find the alcohol industry benefits from a range of incentives, including development assistance, tax breaks, marketing deductions, tax rebates and production subsidies, as well as incentives in the form of international trade agreement practices. Most incentives offered to the alcohol industry are given under the guise of development assistance from governments and development agencies in higher-income countries to low- and middle-income countries; however, the vast majority of beneficiaries of incentives turn out to be the largest alcohol corporations.

Incentives given to the alcohol industry are often justified as economic benefits, to advance economic development, create jobs, or produce much-needed tax revenue. In reality, there is a direct conflict of interest between the economic objectives of governments and development agencies giving incentives to the alcohol industry and public health objectives to reduce the harms caused by alcohol. These incentives essentially promote alcohol on behalf of the industry and create a triple burden for countries—lost revenue, increased alcohol consumption, and overwhelmed public health systems.

This issue of subsidies and incentives has been addressed to a large extent when it comes to tobacco and to a lesser degree with fossil fuels but has not been part of the discussion concerning alcohol.

We recommend the Action Plan include a recommendation that governments and the development community reexamine current economic incentives to the alcohol industry by collecting and monitoring data on incentives, evaluating the health and social costs of incentives, and phasing out incentives that can be harmful to health.

Thank you,

Vital Strategies is an international public health organization. Our programs strengthen public health systems and address the world's leading causes of illness, injury and death. We currently work in 73 countries, supporting data-driven decision making in government, advancing evidence-based public health policies and mounting strategic communication campaigns. Vital Strategies' priorities are driven by the greatest potential to improve and save lives. They include cardiovascular health, tobacco control, alcohol policy, road safety, obesity prevention, epidemic prevention, overdose prevention, environmental health, vital statistics systems building and multidrug-resistant tuberculosis treatment research. Our programs are primarily concentrated in low- and middle-income countries in Africa, Latin America, Asia and the Pacific.

For more information, please contact

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West Indies Rum & Spirits Producers Association (WIRSPA)

Country/Location: Barbados

URL: wirspa.com

Submission

Comment from the Caribbean Rum & Spirits Industry (WIRSPA) on the WHO Web-based Consultation on the Draft Action Plan to Implement the Global Strategy to reduce the harmful use of alcohol

On behalf of the Caribbean rum and spirits industry, the West Indies Rum & Spirits Producers Association (WIRSPA) welcomes the opportunity to provide a comment on the review of the Global Alcohol Strategy (GAS) and the development of a 2022 – 2030 action plan to improve the implementation of the GAS.

The rum and spirits producers of the Caribbean Forum are primarily indigenous companies which have ownership and strong roots in the communities they serve, and are significant employers as well as active exporters, earning much needed foreign exchange.

In 2018 the industry published a joint statement committing to supporting as a group, governments actions to reduce the harmful use of alcohol . It has played a positive role in efforts to develop regional action through a regional Caricom Working Group on the Harmful Use of Alcohol as well as proactive initiatives on improving and updating self-regulation marketing codes and implementing ground-breaking changes to labelling in the domestic markets.

The industry endorses the Global Strategy. We believe it forms a sound basis for actions to reduce the harmful use of alcohol. In particular it sets out a broad set of policy options and actions, while recognising that these should be adjusted as necessary to take into account national circumstances (religious and cultural contexts, national public health priorities and resources).

We believe that as agreed by Member States, the working document and draft action plans should remain focussed on the objectives outlined in the GAS. These should be centred around reducing the harmful use of alcohol and not consumption per se. It should recognise the positive contribution of economic operators and pursue a genuinely whole-of-society approach as mandated by member states.

A more detailed submission is appended.

Attachment(s): 2

00464_01_wirspa-response-to-gas-action-plan-working-document-dec-2020.pdf

00464_02_wirspa-response-to-gas-review-nov-2019.pdf

Comment from the Caribbean Rum & Spirits Industry (WIRSPA) on the WHO Web-based Consultation on the Draft Action Plan to Implement the Global Strategy to reduce the harmful use of alcohol

The WHO Executive Board (EB) requested in February 2020 that the WHO Director-General “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” (Decision EB146 (14)).

On behalf of the Caribbean rum and spirits industry, the West Indies Rum & Spirits Producers Association (WIRSPA) welcomes the opportunity to provide a comment on the review of the Global Alcohol Strategy (GAS) and the development of a 2022 – 2030 action plan to improve the implementation of the GAS.

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The industry endorses the Global Strategy. We believe it forms a sound basis for actions to reduce the harmful use of alcohol. In particular it sets out a broad set of policy options and actions, while recognising that these should be adjusted as necessary to take into account national circumstances (religious and cultural contexts, national public health priorities and resources).

In the 2019 review of the GAS, the Caribbean rum and spirits industry, working in collaboration with the regional beverage alcohol sector, presented a submission³ in the context of the review to which was appended a series of industry commitments around reducing the harmful use of alcohol. This submission is appended to this comment.

We believe that as agreed by Member States, the working document and draft action plans should remain focussed on the objectives outlined in the GAS. These should be centred around

¹ The Forum of Caribbean States includes Antigua & Barbuda, Barbados, Belize, Haiti, Dominica, the Dominican Republic, Grenada, Guyana, Jamaica, St. Kitts/ Nevis, St. Vincent & the Grenadines, St. Lucia, Suriname, and Trinidad & Tobago.

² [WIRSPA Statement on Responsible Drinking, 2018](#).

³ WIRSPA Response to the Review of the WHO Global Strategy to Reduce the Harmful Use of Alcohol (the GAS), November 2019.

reducing the harmful use of alcohol and not consumption per se. It should recognise the positive contribution of economic operators and pursue a genuinely whole-of-society approach as mandated by member states.

Measuring Harm – Heavy Episodic Drinking versus Per Capita consumption

We endorse the positive trends reflected in the review that point to a decline in drinkers across all regions, and a decrease in heavy episodic drinking. Specifically, we note substantive declines in measures of alcohol harm in the Americas in relation to Heavy Episodic Drinking and Alcohol Attributable Deaths with men and women drinking less and less persons drinking.

Topline trends from 2018 Global Report for the Americas Region for the period 2010 - 2016:

- **Alcohol attributable deaths down worldwide by 5%, and for the Americas by 5.7%.** Another measure, Alcohol Attributable Disability-Adjusted Life Years (DALYS) is also down 6%.
- **Alcohol Per Capita (APC)⁴ in the Americas has dropped to 8 litres, a decrease of 2.4%.**
- **Heavy Episodic Drinking (HED) is down 10.8% for the Americas.**
- **Among adolescents (15-19) and young adults (20-24) drinkers only, HED is down by 5% over the 5-year period, and 8% over the decade.** HED is a particular concern in these two age groups. For the total population in these two groups HED is down 13.6% and 10.3% respectively.
- **Men and women are drinking less, down by 5% and 8% respectively over the past 5 years.** The report stresses the high level of drinking by men and rightly so, however this downward trend is continuing over the past decade (2005) with reductions of 8% and 14% respectively.
- **Less persons are drinking: current drinkers are down 6%; former drinkers are up 12% and lifetime abstainers are up 4%.**

With few exceptions, all of these metrics reflect a continuing trend over the past decade and a half, as set out in the Global Status Report.

These are all positive trends to be built on and are accompanied by a broadly stable overall consumption per capita, the Americas, as reflected in the 2018 WHO Global Status Report on Alcohol and Health.

While we agree that current levels of harm remain unacceptably high and that urgent action is required, we find that the overriding emphasis in the Working Document on per capita consumption is not the most effective measure of harm.

As heavily tourism dependent countries with large diaspora populations making up a substantial portion of the visitors, the estimation of true per capita consumption has proven to be highly

⁴ The alcohol beverage sector has consistently argued that this measure is not an accurate measure of alcohol harm, nor is it accurately calculated for our tourism dominated economies.

problematic. In many countries which make up the Caribbean Forum and the membership of WIRSPA, the diasporic visitors constitute a substantial informal export of products which are not registered as duty-free. In addition, for some smaller territories, the presence of international 'off-shore' schools with non-permanent young students (22-30 year olds) and high disposable income present a skewed consumption pattern not addressed by WHO data analysis. The result is that for the Caribbean, countries which have markedly similar cultures and drinking practices, are represented in WHO data as having substantively different per capita consumption patterns.

Similarly, attempts to capture unrecorded alcohol in the WHO 2018 report appears highly flawed. Specifically, unrecorded alcohol is presented at virtually identical levels in countries which have an acknowledged high incidence of illicit alcohol (e.g., the Dominican Republic), compared to those having virtually none (Barbados).

Although It is considered too early to accurately assess alcohol consumption during Covid, many initial studies show a decrease in Heavy Episodic Drinking, including the recent PAHO study⁵. It is instructive to observe that on an aggregate level, beverage alcohol sales in the Caribbean have fallen in 2020, with higher reductions in countries who continue to implement lockdown measures due to continuing high infection rates.

We argue that the global target (Action Area 1) proposed in the Working Document which focusses exclusively on per capita consumption is impractical and unworkable for the Caribbean.

Globalisation and De-regulation – a skewed perception

The Working Document presents a picture of an alcohol industry that is highly globalised and is benefitting from increasing deregulation. For the Caribbean, the indigenous alcohol beverage industry remains rooted in the domestic markets, albeit with increased international ownership. These indigenous brands have maintained market space due to their production in-market and close connection to communities.

In direct contrast to the picture presented in the Working Document, external ownership where it exists has brought international best practice to advertising and marketing practices, resulting in a marked improvement across the board of brand marketing codes and consumer information (e.g., labels).

Indeed, the past decades have seen a marked change in culture towards what is acceptable in alcohol marketing and increased compliance with local regulations where they exist. Joint industry action in the WIRSPA membership and across the broader beverage alcohol sector has seen the adoption of common marketing codes that better protect underage and vulnerable populations, and address crosscutting issues such as digital marketing.

⁵ Alcohol Use during the COVID-19 pandemic in Latin America and the Caribbean, 8 September 2020, PAHO

Recommended Policy options and interventions

The working document, while referencing the broad set of policy options and interventions set out in the GAS in 2010⁶, focusses more narrowly on a limited set of interventions presented through the Safer package which focus primarily on the so-called best buys. As a technical instrument developed by the WHO (without endorsement of member states) the SAFER package effectively works to reduce attention on other effective policy options. For example, whereas SAFER makes no reference to awareness and education, Caribbean stakeholders firmly believe that this has to be a major component in any action plan. Similarly, in a region where there is a real need to update legislation around alcohol, the action plan makes no reference to LPA legislation and regulation.

From a practical point of view, in a region where excise taxation of alcoholic beverages has risen steadily over decades, and where the opportunity to shift consumption to illicit alcohol is high, the role of taxation is limited. In particular, the potential for informal trade in the small island states and sparsely populated mainland territories is very high. History has demonstrated that changes in taxation are directly linked to surges in cross-border and inter-island smuggling. Other SAFER measures such as restricting availability is problematic for countries where the tourism package is strongly identified with a cultural experience that includes indigenous beverages such as rum.

Perhaps most importantly, the exclusive attention to the Best Buys, which are the specific focus of the Safer package, have effectively narrowed the conversation around effective policy option and measures, and resulted in a lack of attention to other actions.

A whole-of-Society Approach

The GAS firmly positions the need for a whole-of-Society approach that incorporates economic operators. Despite this, the action plans set out in the Working Document proscribe the actions of economic operators to a very limited sphere of activity. Considering that many of the regulatory improvements in the Caribbean have been driven by the economic operators through marketing codes and improved labelling, limiting the input of the industry appears to be unnecessarily limiting and could lead to less effective actions.

In the Caribbean, Caricom has set up in 2019 an intergovernmental working group on the harmful use of alcohol. The alcohol beverage industry has played a collaborative and positive role in the development of a draft action plan and expects to continue this positive interaction. Nevertheless, there continues to be a reluctance on the part of health advocates (strongly

⁶ These included leadership, awareness, and commitment; health services' response; community action; drink-driving policies and countermeasures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; and monitoring and surveillance

supported by the WHO sub-office) to prevent any input whatsoever from economic operators, even where objectives are the same – i.e., in establishing strong LPA regulation.

Notably the action plan set out in the Working Document does not provide space for collaborative action between economic operators and stakeholders. Many examples of successful interaction already exist –drink driving programs in Trinidad & Tobago where work with the enforcement agencies has led to a positive impact on drink-driving, and in the Dominican Republic with the Ministry of Transport. In the Eastern Caribbean States, awareness programs in schools in collaboration with ministries of Education. Responsible drinking and server educations programs in Jamaica. A broad range of education, awareness, and drink-driving initiatives in Suriname.

Specifically, with regard to labelling, rum & spirits producers in 2019 made a commitment to improve labelling in the regional market. Already in 2020, [several brands already carry](#) serving and calories information, as well as advice logos warning against underage drinking, drinking & driving, and drinking in pregnancy.

The contribution of the economic operators during Covid demonstrate a whole-of-society approach where the sector worked to provide support to governments efforts to reduce the impact of the pandemic. In the Caribbean rum & spirits producers made substantial contribution to the urgent need for sanitisation products, exacerbated by a cessation in international shipping.

Throughout the WIRSPA membership some 600,000 litres of alcohol in various forms was donated to essential service and health agencies by mid-2020, as well as care home and educational institutions. Aside from these donations beverage alcohol producers were able to pivot to manufacture of sanitisation products to ensure a supply of these products to the public in the absence of imported products because of closed borders and absence of shipping possibilities.

end

WIRSPA Response to the Review of the WHO Global Strategy to Reduce the Harmful Use of Alcohol (the GAS)

Introduction

1. As crafted, the 'Global Alcohol Strategy' (GAS) provides a sound basis for actions to reduce the harmful use of alcohol. We believe the broad strategy and target actions remain relevant today as they were 10 years ago. The GAS sets out a broad set of target areas for action and addresses the requirement for actions to be relevant and appropriate in the national context.
2. The GAS also describes a clear role for the private sector in working with governments and other interest groups and emphasises a focus on reducing the harmful use of alcohol, as opposed to alcohol consumption *per se*.
3. The Caribbean Community, in endorsing the 'Whole of Society' approach recently established a Working Group comprising the health sector, regional agencies and the private sector to prepare recommendations on actions to reduce the harmful use of alcohol.
4. The Working Group is a clear expression of the 'Whole of Society' approach described in UN SDG #17 endorsing public-private and civil society partnerships, as well as the commitment by UN Heads of Government HLM in 2018 to engage with the private sector to reduce alcohol harm.
5. This initiative has catalysed collaborative action on the part of the rum industry acting in concert with other caribbean beverage alcohol sector stakeholders to agree substantial and paradigm-shifting commitments to reducing alcohol harm. The sector understands that a major adjustment needs to be made in the way responsible consumption is conveyed and to address the widespread social acceptance of excessive consumption. These commitments are set out in the annex to this note.
6. Whilst we are broadly supportive of the GAS review and its findings, it is necessary to respond specifically to several areas of concern.

Emphasis on Negative Commercial Motives

7. While member states have endorsed a 'Whole of Society' approach, there is an increasing trend, reflected in the review, to portray all commercial interests as acting against governments' sovereign authority to work to improve the health of this citizens. This is an unfortunate, and we believe inaccurate, representation. While not seeking to deny that such conflicts are possible and have been experienced, the Caribbean rum industry and other beverage alcohol stakeholders are largely indigenous operators situated in and owned by the communities they serve.
8. The positive and proactive evidence of the Caribbean beverage alcohol sector is evidenced by the commitments reflected earlier and annexed in more detail to this paper.

9. We are indigenous brands and operators deeply rooted in the communities in which we serve, we have a responsibility to do the best we can in ensuring persons consume our products responsibly.

Exclusive Focus on the 'Best Buys'

10. We note that the WHO and PAHO have promoted almost exclusively, the three so-called 'best buys' as being the most cost-effective interventions to reduce the harmful of alcohol, viz: regulating availability; restricting/banning advertising & promotion; and increased taxation.
11. We agree that there is room for improvement on regulatory and other aspects of availability and advertising in many of our territories. As reflected further along in this paper, we support a co-regulatory framework to govern the marketing and sale of alcoholic beverages.
12. We fully support a balanced approach to taxation that is evidence based and takes into account local conditions. However, we must also be cognisant that as an already highly taxed product there is a well-documented connection between price and illicit alcohol smuggling, grey market and illegal production - and its impact on health.
13. Our countries, whether continental or island states, are seriously challenged to police our borders and the growth of illicit alcohol is an ongoing challenge that results in severe tax losses for many countries.
14. While increasing regulation around marketing, taxation and availability are recognized policy options, they are not the only policy options that may work effectively in our region. We welcome opportunities to collaborate with all stakeholders on the target areas defined in the GAS and initiatives such as SAFER.

Alcohol Attributable Harm and its Measurement

15. The review correctly reflects recorded reductions in HED surpassing 10% in the Americas for 15+ adults and adolescents (15-19). Nevertheless, we agree that Heavy Episodic Drinking (HED) in the Caribbean is at unacceptable levels, and that this is a key concern for regional health authorities and our governments. We agree that the incidence of HED among adolescents and young adults as well as other vulnerable populations such as pregnant women and the elderly should be of particular concern.
16. The growth of festival culture is a major social phenomenon in the Caribbean which draws in young people and provides drinking opportunities, but it poses particular challenges that cut across several areas including underage consumption, excessive consumption and drink-driving. We acknowledge more needs to be done to minimize harmful drinking during these periods.
17. The WHO has increasingly emphasised alcohol per capital consumption (recorded and unrecorded) as the sole measure of progress in relation to reducing the harmful use of alcohol. This is at the expense of other arguably more useful indicators such as the prevalence of Heavy Episodic Drinking among adolescents and adults; and alcohol related mortality and morbidity.

18. Our countries have levels of consumption significantly impacted by the relatively large number of visitors who are such an important part of our economies. Visitor consumption is not properly accounted for in consumption data and leads to a far higher apparent per capita number than actual.
19. Per capita consumption for our heavily tourism-oriented countries is therefore a very poor measure of consumption by residents – a fact recognised by a leading provider of such data¹.
20. In specific cases the impact of tourism consumption has caused significant adverse media attention² on some countries and resulted in a level of stigmatisation. The absence of accurate and effective data underlines the need for the collaboration with the private sector to improve data collection.
21. Moreover, the conflation of *alcohol consumption* with the *harmful use of alcohol* serves to detract from the targeted nature of action to reduce alcohol attributable harm.

Sector Achievements

22. Across the Caribbean Community the publication of the GAS gave impetus to the formation of national private sector grouping across most countries. While not all of these are active, several have played a significant role and serve as best practice examples of how the private sector can work positively to reduce the harmful use of alcohol.
23. Several best practice examples are:
 - Suriname (Suriname Foundation for Responsible Drinking) – a range of actions across all areas of education and awareness
 - Trinidad & Tobago (Trinidad and Tobago Alcohol Beverage Alliance) – active interventions in many areas of education and a strong focus on drink-driving with highly positive results
 - The Dominican Republic- collaborative venture between producers and importers with public stakeholders to implement a strong drink-driving initiative.
24. In many cases, there are strong self-regulation codes in place. The impact of these codes is however diminished by the absence of broad adoption across all players in the national context, leading to a major challenge with compliance across all operators.

¹ IWSR Report, Barbados, 2018 “Caveat...Throughout the year the population of the island is swelled by the arrival of significant numbers of tourists. It is impossible to make any distinction between total local and tourist consumption... As a result, any per capita consumption figures derived from this report will be distorted... This report is unable to distinguish between these volumes and those consumed by stay-over tourists and the local population.”

² <http://www.nowgrenada.com/2014/05/grenada-tops-regional-alcohol-consumption/>.
<https://www.stlucianewsonline.com/st-lucia-ranked-in-top-10-worldwide-for-highest-alcohol-consumption/>

25. The sector has also been active, where permitted in supporting education initiatives in several countries. These include awareness programs in educational institutions across several Eastern Caribbean Countries.
26. Moreover, recent initiatives by the regional rum industry on updating advertising codes (with special emphasis on digital marketing) and upgrading of product labels is expected to benefit from broader adoption across other sector stakeholders.
27. The beverage alcohol sector will fully participate in international efforts working with social media platforms to better control the delivery of content to underage persons or those who do not wish to receive it.
28. Most of all, recent initiatives have catalysed specific commitments on the part of the sector, provided in more detail in the annex. Importantly the sector commits to arranging independent assessment of actions agreed by our ourselves on an annual basis.
29. Key to the success of our commitments will be the full involvement of all players in the sector, agreement on activities and targets and a review mechanism to measure success. We believe these undertakings will support government efforts to reduce the harmful use of alcohol.
30. We also believe their success will be firmly predicated on continuing dialogue between all stakeholders through appropriate and ongoing consultative mechanisms, both regionally and at the national level.

ANNEX - INDUSTRY COMMITMENTS

POLICIES THAT <i>WE SUPPORT</i>	THINGS THAT <i>WE UNDERTAKE TO DO</i>	STATUS OF ACTIONS
Promoting Responsible Drinking		
<p>➤ We support a change in the messaging and culture surrounding drinking which does not glorify or promote excessive consumption, and which seeks to provide consumers with information on the health risks of harmful consumption.</p>	<p>We will:</p> <ul style="list-style-type: none"> – Integrate within all of our marketing communications, information concerning health risks and responsible drinking messages that go beyond an exhortation to ‘Drink Responsibly’ – Seek practical solutions to supporting efforts of other stakeholders to educate and raise awareness – Support workplace health programs that create an environment that promotes wellness 	<p>Across-the-board efforts are underway to upgrade labelling, adopt and improve advertising codes, and digital media, as set out in more detail below.</p> <p>Special attention will be paid to address underage drinking and drinking in pregnancy.</p> <p>The BAS is beginning to catalyse groups across individual countries to engage with stakeholders on a national basis to tackle these issues.</p>
Preventing Drink-driving		
<p>➤ We believe it is not acceptable to drink and drive. However very few CARICOM countries have legislation to enforce drink-driving restrictions and to mount sobriety checks.</p> <p>➤ <u>We support the introduction of strong drink driving legislation and the introduction of breathalysers.</u></p>	<p>We will:</p> <ul style="list-style-type: none"> – Work with Police departments and other NGOS to implement sobriety checks especially around events – Incorporate drink-driving messaging across all promotions and product labelling – Mount collaborative awareness programs using a variety of messaging and particularly social media channels – We will call on policy makers to support the use of evidentiary breathalysers to enforce BAC laws and suitable sanctioning of offenders. 	<p>Strong Drink-Driving policies are already in place in Trinidad and recently launched in the Dominican Republic.</p> <p>In both countries the BAS has contributed to the procurement of breathalysers.</p> <p>The BAS is working in several other countries to support the introduction of strong drink-driving legislation.</p>

ANNEX - INDUSTRY COMMITMENTS

POLICIES THAT <i>WE SUPPORT</i>	THINGS THAT <i>WE UNDERTAKE TO DO</i>	STATUS OF ACTIONS
Reducing Underage Drinking		
<ul style="list-style-type: none"> ➤ Many Caricom countries have outdated and inadequate legislation concerning legal purchase age. In several case an age is not specified, or it is less than 18. ➤ <u>We support the introduction of a legal purchase age across CARICOM that enforces a minimum age for the purchase and consumption of alcoholic beverages.</u> ➤ We support amendments to legislation such as the liquor license acts, to require age verification for purchase and consumption. 	<p>We will:</p> <ul style="list-style-type: none"> – Incorporate in all sponsorship agreements, conditions that restrict alcohol availability to underage persons in events and promotions. – Strengthen compliance with marketing codes to ensure marketing does not primarily appeal to minors and that persons portrayed in ads are over 25 years old and are perceived to be so. – Collaborate with governments and NGOs to support educational initiatives, building on successes, in the educational system 	<p>The BAS will work in all states to promote the adoption of strong LPA regulation.</p> <p>In Barbados these changes are already in a draft bill and publicly endorsed by the BAS. As a complementary measure it is hoped that retailers will be legally required to carry signage stating LPA rules and requiring identification for purchase of alcoholic beverages.</p> <p>WIRSPA members have agreed to develop a policy on the responsible marketing of Ready-to-Drink products to ensure that such products are responsibly labelled and marketed so that underage consumers are not targeted.</p> <p>Over the past 5 years the BAS has collaborated with education ministries in several countries to pilot awareness programmes on the dangers of alcohol (such as Ask-Listen-Learn in the OECS). The sector will engage authorities nationally to broaden the scope and reach of awareness programmes.</p>

ANNEX - INDUSTRY COMMITMENTS

POLICIES THAT <i>WE SUPPORT</i>	THINGS THAT <i>WE UNDERTAKE TO DO</i>	STATUS OF ACTIONS
Regulating Advertising and Marketing		
<ul style="list-style-type: none"> ➤ We support a balanced framework of co-regulation that sets appropriate boundaries for balanced advertising and promotion. ➤ Specifically, we support public regulation that provide a level playing field for producers and sellers and protects consumers. 	<p>We will seek adoption in all territories of up-to-date self-regulatory advertising & marketing codes that:</p> <ul style="list-style-type: none"> – Reflect best practice in responsible drinking, do not link alcohol and health, sporting success, skill, or portray social and sexual success – Reflect abstinence as a valid individual choice, and that no link should be made to alcohol as a rite of passage to adulthood – Work to restrict marketing to underage and vulnerable populations, esp. pregnant women – Enshrine strong sponsorship and trade promotion provisions – Incorporate comprehensive digital principles to manage online and social media channels such as: <ul style="list-style-type: none"> ○ age affirmation ○ placement of marketing communications ○ Forward advice notices and content sharing ○ Incorporate responsible drinking messages ○ Manages User Generated Content <p>Further, we will:</p> <ul style="list-style-type: none"> – Ensure that our staff and service providers are trained in the principles enshrined in our codes – Develop internal processes within our companies to ensure compliance with our codes – Ensure non-industry involvement in the oversight of our code compliance and implement an annual 360-degree published assessment 	<p>A new best practice code has been adopted by WIRSPA members in June and efforts are underway to have it implemented by other BAS members.</p> <p>WIRSPA will conduct an assessment of implementation at the end of 2019, with particular focus on code compliance in social media marketing.</p> <p>Producers have been tasked with bringing all social and other digital media, both in house, and also controlled by distributors, in line with best practice digital principles as set out by the International Chamber of Commerce (ICC).</p> <p>Further the BAS has agreed to an annual independent assessment of its compliance with its codes.</p>

ANNEX - INDUSTRY COMMITMENTS

POLICIES THAT <i>WE SUPPORT</i>	THINGS THAT <i>WE UNDERTAKE TO DO</i>	STATUS OF ACTIONS
Improving Consumer Information and Labelling		
<p>➤ We support regional standards and regulations that require best practice in brand information and products labels</p>	<p>We will:</p> <ul style="list-style-type: none"> – Incorporate messaging on our labels to warn against drink-driving, underage consumption and drinking in pregnancy – Indicate serving sizes and calories per serving as well as per 100ml – Indicate net contents and alcohol on front labels – Incorporate Responsible Drinking messages – Ensure all elements are legible and printed on contrasting background to aid readability. – Duplicate this information in all online content 	<p>WIRSPA members are moving to implement these label changes in domestic markets announced in June 2019.</p> <p>The changes involve the incorporation of visual warning logos against underage consumption, drink-driving, and drinking in pregnancy.</p> <p>New labels will also include number of standard drinks per serve, listing of calories per serving, and number of serves per container.</p> <p>Minimum size and legibility specifications have been agreed for alcohol strength and product volume on primary labels.</p> <p>We expect to see new labels by many brands by early 2020. Some producers are already placing new labels on the market.</p> <p>It is expected the remainder of the BAS will seek to adopt these labelling upgrades.</p>

ANNEX - INDUSTRY COMMITMENTS

POLICIES THAT <i>WE SUPPORT</i>	THINGS THAT <i>WE UNDERTAKE TO DO</i>	STATUS OF ACTIONS
Working with Retailers and Promoters to reduce Harmful Drinking		
<p>➤ We support the implementation of sensible drinking guidelines for promotions and events that do not encourage excessive drinking, shot culture and drinking games.</p>	<p>We will:</p> <ul style="list-style-type: none"> – Work with bars and restaurants to promote server training around age verification, recognising and addressing inebriation and providing support for transportation alternatives – Incorporate responsible drinking messaging in all on and off trade outlets with clear messaging relating to drinking age regulation. Where this is not in place the referenced age will be 18years old. – Within sponsorship contracts for events we will ensure events are responsibly marketed and include responsible drinking messages in their marketing and at the event. – Require event organisers to implement age verification and adhere to the sensible drinking guidelines set out in our codes 	<p>We have begun work in several areas:</p> <ul style="list-style-type: none"> – Development of a template contract for use by brands with promoters that requires a series of commitments to responsible serving. – A collaborative effort to introduce signage in on and off-trade to signal LPA and to require identification on purchase.

Winooski Partnership for Prevention

Country/Location: United States of America

URL: www.WinooskiPrevention.org

Submission

The WPP is pleased to see the work done by WHO on this issue. The following are some comments about what we think could be better, or more impactful.

Right now, there is a lack of specific time intervals for review and reporting of the implementation of the action plan; reporting should happen regularly influence of commercial interests on policy.

There is a need for a strong public health agenda to face the large corporate interests, in order to make real progress.

There is a need for more resources for less wealthy nations to keep their populations healthy.

A global strategy will need to be coordinated and implemented. Modeling from the tobacco work done previously would strengthen this work. We believe the WHO should allocate funding to this effort. The policies that have the biggest positive impact and save the most money 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. We believe this should be considered in the section on "Key Areas for Global Action."

Try to normalize sobriety, or non-drinking, also as normal. In many cultures and populations non-drinking is the norm. Cultural traditions of alcohol use are grounded in informal and 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.

In Action area 3, Action 3 for NSA, we agree that economic operators in alcohol production and trade should be 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. In the working document on page 16, but should be rewritten to include: "abstain from engaging in and/or interfering with".

Also, data should be collected every 1-2 years, rather than 4-5 years, to be effective and usable in policy development.

We do not think that the alcohol industry has a legitimate interest in reducing marketing to minors or in encouraging temperance in alcohol use, because of their need to attract youth users in order to ensure future profitability, since over 70% of their profits come from users with dependence and use disorders. Therefore, it does not seem to benefit public health to "invite" them to work toward this end.

Finally, the role for the Secretariat seems like it could be expanded and clarified in this effort.

The WPP agrees that the WHO effort must remain independent financially from alcohol industry influence.

Thank you for your time and consideration.

Attachment(s): 0

World Cancer Research Fund International

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

URL: www.wcrf.org

Submission

Please find attached the submission from World Cancer Research Fund International

Attachment(s): 1

00023 WCRF International response to 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

**Response prepared by World Cancer Research Fund International
December 2020**

Introduction

World Cancer Research Fund International (**WCRF International**) leads and unifies a network of cancer prevention charities with a global reach. We are the world's leading authority on cancer prevention research related to diet, weight and physical activity. We work collaboratively with organisations around the world to encourage governments to implement policies to prevent cancer and other non-communicable diseases (NCDs). WCRF International has been in official relations with WHO since 2016.

WCRF International supports the development and implementation of effective policies to enable people to follow [WCRF International's Recommendations for Cancer Prevention](#). Evidence shows that effective policy implementation will reduce the chances of people developing cancer and other NCDs.

Alcohol use and cancer risk

The harmful use of alcohol is a public health problem and among the main drivers of the global epidemic of premature deaths from non-communicable diseases. Our [Third Expert Report](#) found that there is strong evidence that alcoholic drinks increase the risk of 8 types of cancer, and one of our Cancer Prevention Recommendations is to limit alcohol consumption. Consequently, WCRF International supports policy measures and efforts that reduce alcohol consumption and overall harm.

The development of alcohol control measures through evidence-based policy development and implementation, an increase in the allocation of resources and strengthening of political will are all necessary in order to accelerate progress on decreasing alcohol harm. Our [Driving Action Policy framework](#) highlights a range of actions that can be taken to reduce alcohol consumption.

Part 1: Our comments on the Working Document

We have prepared several comments about the working document for consideration.

1. Layout and accessibility

The working document uses clear and concise language, with a logical structure, starting by setting the background and reaching to the proposed actions, which is easy to follow. Regarding the tone, it mainly 'invites' the non-State actors and international partners to take action but instructs the WHO secretariat and Member states to act on the proposed actions. However, the document would benefit from a reduction in the numbers of the action points and targets to ensure that all elements of the plan are achievable within the time frame of the plan.

2. Key positive aspects

The document has several positive aspects, which we would like to note:

- a. It recognises the global inequity due to lack of policy in lower- and middle-income countries (LMICs) and the lack of implementation by member states and focusses on ways to drive action.
- b. It also acknowledges the importance of political will in driving implementation as well as the current lack of resourcing available to implement the action plan.
- c. It also recognises the important role civil society can play, and the harmful effect of conflict-of-interest processes on the implementation of the Global Action Plan.
- d. It includes strong, updated evidence endorsed by WHA for the non-communicable diseases (NCDs) set of affordable, feasible and cost-effective intervention strategies - Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases - (to be referred to as 'Best Buys' henceforth).

3. Background information

The working document provides a comprehensive introduction to the Global Strategy to Reduce the Harmful Use of Alcohol, the steps of developing the Strategy, its aim, vision and purpose. Providing additional information on the progress since the development of the Strategy nicely sets the background and purpose of developing the current action plan.

However, it would benefit from further additions. For example, there is a lack of background information on the corporate strategies of the Trans National Alcohol Corporations (TNACs), including their targeting of LMICs for growth in sales as new and emerging markets. In addition, there is no discussion on the lack of regulation of the TNACs and digital platforms used to target vulnerable consumers. Finally, the cultures and populations where alcohol is not an embedded part of the culture should be highlighted.

4. Goals and Principles

We welcome the goals and principles, especially around managing conflict of interest through the protection of commercial interest. However, we have concerns that the Global strategy guiding principles regarding these protections, namely around conflict of interest, are not reflected in the development of action plan. Specifically, we believe that:

- a. Attention should be paid to ensure that the principle is laid out comprehensively in the Global strategy and clear conflict of interest guidelines in the action plan should be developed, incorporated, and operationalised.
- b. The development and implementation of effective national alcohol policy should be free from industry influence and should be reinforced throughout the action plan.
- c. Conflict of interest guidelines in SAFER should be developed which will be promulgated with participating Member States.

5. Objectives

We believe that the need for global action and an international response should be highlighted under the objectives.

In addition, objectives 4 (page 7 '*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*') and 5 (page 8 '*improved systems for monitoring and surveillance at different levels, and more effective dissemination and application of information for advocacy, policy development and evaluation purposes*') are overlapping and objective 5 should be adjusted to have a clearer accountability objective.

6. Stakeholders

We have several comments about the roles of stakeholders:

- a. WHO and Member States should consider strategies to manage conflict of interest in the development and implementation of the proposed action plan, including details of meetings held between WHO Secretariat and the alcohol industry to be publicly available, records of participants, meeting costs, discussion topics and actions included.
- b. At no stage in the action points is there any mention of a role for the 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. Accountability measures could be strengthened by mandating a role for the Secretariat.

7. The role of civil society and NGO non-state actors

We have several comments about the engagement of non-state actors and civil society:

- a. WHO and Member States should consider strengthening the provisions of WHO Framework for Engagement with Non-State Actors (FENSA) to include specific reference to alcohol industry in relation to conflict of interest, and to improve the implementation of FENSA.
- b. The structure of the action statements should not include a role for economic operators. Currently economic operators are positioned as equivalent to other Non-state actors. This can lead to 'invitations' to economic operators to implement the plan, which could be skewed by their commercial motivations

and responsibilities to shareholders. Economic operators rely on substantial sales, which can include heavy drinking occasions and individuals with alcohol use disorder.

- c. Relying only on civil society for monitoring industry interference reduces the capacity of civil society to engage in policy development and implementation processes. Member States and the WHO Secretariat should also have a role to play.

8. Timeline and milestones

The WHO EB decision 146(14) asks for an action plan 2022-2030 and for a report on the review of the Global strategy to reduce the harmful use of alcohol in 2030. That will be twenty years after the Global strategy was endorsed. We believe that this is too late and that there will not be effective mechanisms to assess progress. We urge:

- a. Member States should make a resolution in 2022 calling for an Expert Committee and/or
- b. Review in 2024 the Global strategy with a mid-term review.

9. The use of international legal instruments

The WHO should commit to explore the possibility and feasibility of legally binding instruments and review the evidence to assess how an instrument could contribute to a reduction in alcohol harm and an increase in alcohol control. Legal measures have proved effective in managing other NCD risk factors.

10. Comments on the Action areas

We have prepared a number of general comments which can be applied across the action plan:

- a. WHO and Member States must ensure that the action plan has sufficient monitoring and evaluation mechanisms and clear-cut accountability measures specifically in relations to the 'Best Buys'.
- b. The actions highlighted in the working document should be SMART, however there is lack of specific time intervals for review and evaluation. Consequently, it is very difficult to assess progress.
- c. The working document clearly acknowledges the disproportionate impact of alcohol on the LMICs but does not include targeted action to address the issue.
- d. WHO needs to be resourced at all levels, including in regional and country offices, to be able to give substantial and appropriate technical assistance to Member States to reduce alcohol harm through the implementation of SAFER, including protection against conflict of interest.
- e. WHO Secretariat should establish and strengthen ongoing channels of communication with SAFER partners and Member States to achieve wide take-up of the SAFER technical package and development of national alcohol regulations.
- f. WHO Secretariat should initiate communication with relevant UN agencies and develop collaborative initiatives to promote the contribution of alcohol control to the development of the Sustainable Development Goals. We believe the

working document should encourage all aspects of SAFER being implemented - a comprehensive approach to all policy options should be advocated.

- g. We believe a specific date for the convening of the WHO Expert Committee on Problems Related to Alcohol Consumption should be specified.

11. Accelerating action and priority areas

We believe that the following elements should be priority areas:

- a. WHO and Member States need to ensure that the 'Best Buys' are not diluted in the action plan and that measures are put in place to measure the uptake and implementation of the 'Best Buys' policies. Pricing policies must include health tax on alcohol to reduce harm and recycle revenue to support implementation of 'Best Buys'.
- b. WHO and Member States must ensure that the action plan has sufficient monitoring and evaluation mechanisms and clear-cut accountability measures specifically in relations to the 'Best Buys'. Regular evaluation of the progress made is required, and revisions made to the plan, where evidenced and deemed necessary.

12. Accountability: Monitoring and evaluation

There is a 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, the Director-General should 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 to ensure there is no further delay to proportionately addressing any persistent barriers to progress identified through the course of the Action Plan.

13. Existing barriers to effective implementation

We highlight several barriers to implementation.

- a. Alcohol industry actors are well organised and well mobilised in influencing national policy making.
- b. E-commerce in trade agreements, "designed to keep the digital domain, as far as possible, a regulation-free zone", pose new obstacles to national efforts to regulate the availability of alcohol.
- c. Alcohol control is severely under-funded, compared to other public health challenges. There is also a lack of resource within WHO to serve this area.
- d. There is a lack of political will within Member States to design and implement policy measures outlined in the SAFER technical package and in the 'Best Buys'.

14. Additional recommendations to catalyse action

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 all of 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 lack of political will is highlighted as one of the barriers on the implementation of alcohol policy. However, the working documents does not mention how this issue could be tackled, for example, a summit could be a way to catalyse political leadership.

15. Examples of learnings from other Action Plans

An annex report from the United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases¹ highlighted pervasive industry attempts to influence government policy, comparing activities of the alcohol industry with that of the tobacco industry, which can provide useful learnings.

Key learnings include:

- a. Interference by industry impedes the implementation of the 'Best Buys' and other recommended interventions, including raising taxation on tobacco, alcohol and sugar-sweetened beverages.
- b. Multinationals with vested interests routinely interfere with health policy-making, for instance by lobbying against implementation of 'Best Buys' and other recommended interventions, working to discredit proven science and bringing legal challenges to oppose progress. In some instances, these efforts are actively supported by other countries, for instance through international trade disputes. Industry interference is one of the commercial determinants of health, a concept that extends to governmental policies and practices such as trade promotion.
- c. Member States should be encouraged to explore the emerging idea that the income they receive from taxation of the global revenue derived by multinational companies based in high-income countries from the sales of tobacco products, alcoholic beverages and sugar-sweetened beverages in low-income and middle-income countries could be ploughed back – through official development assistance – into low-income and lower-middle-income countries in order to support their national efforts to implement the 'Best Buys' and other recommended interventions for the prevention and control of noncommunicable diseases.

¹ WHO. Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018; Report by the Director-General. EB142/15. 22 December 2017. https://apps.who.int/gb/ebwha/pdf_files/EB142/B142_15-en.pdf

- d. WHO should provide guidance to Member States on how to implement and strengthen national alcohol control policies.
- e. WHO could develop an approach that can be used to register and publish the contributions of non-State actors to the achievement of the alcohol 'Best Buys'.

16. Insights from other NCD risk factors

We believe there are several learnings from other NCD risk factors.

- a. Promote all areas of the SAFER technical package and urge Member States to adopt a comprehensive approach to action in all 5 areas. Furthermore, Member States should prioritise mandatory regulatory responses over voluntary ones.
- b. Addressing the alcohol industry interference as a major determinant of people's health and well-being is a formidable challenge, that goes beyond public health. Strict conflict of policy policies need to be developed and enacted.
- c. Tracking and monitoring alcohol as a risk factor for disease, multi-morbidity and pre-mature death is vital to assess progress.
- d. A shift in mindset from expenditure to investment thinking regarding health spending is one way to drive political will.

17. Conflict of interest and '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.

WHO and Member States should consider conflict of interest in the development and implementation of the proposed action plan, including details of meetings held between WHO Secretariat and the alcohol industry to be publicly available, records of participants, meeting costs, discussion topics and actions included.

Part 2: Recommendations for advancing alcohol policy

1. Overcoming barriers to alcohol control advocacy

- a. Alcohol is a delicate topic – Public acceptance around regulation on purchasing and consumption is challenging, given how alcohol is ingrained in many cultures.
- b. Industry lobbying is very strong, and the alcohol industry has a fundamental conflict of interest with many elements within the working document. Therefore, we believe the working document should be strengthened to:

1. Safeguard the NCDs response on all levels against conflicts of interest, avoid undue influence of the alcohol industry and refrain from incompatible partnerships.
2. Identify and regulate the alcohol industry as a vector in the NCDs epidemic and a commercial determinant of health and development.
3. Put the public interest and Human Rights, including the Convention on the Rights of the Child, at the centre of all efforts to prevent and control NCDs and their risk factors.

2. Adopting a comprehensive, whole-of-government, whole-of-society approach

A whole-of-government, whole-of-society approach is necessary to create environments for people and communities that are conducive to limiting alcohol consumption.

A comprehensive package of policies is needed to reduce alcohol consumption at a population level, including policies that influence the availability, affordability and marketing of alcoholic beverages. Policymakers should be encouraged to frame specific goals and actions according to their national context.

For more information:

This consultation response was prepared by Margarita Kokkorou, Policy & Public Affairs Officer and Kate Oldridge-Turner, Head of Policy and Public Affairs. For any queries about WCRF International's submission, please contact policy@wcrf.org.

World Federation of Advertisers

Country/Location: Belgium

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

Submission

WFA submission abstract:

Cross-Border Alcohol Marketing Communications: What do we mean by cross-border marketing and what is the size of 'the problem'?

The World Federation of Advertisers (WFA) welcomes the opportunity to contribute to the working document for development of an action plan to strengthen implementation of the global strategy to reduce the harmful use of alcohol.

WFA is the voice of marketers worldwide, representing 90% of global marketing communications spend, over \$900 billion per year. We represent over 120 brand owners and 60 national advertiser associations worldwide.

WFA welcomes the call for economic operators in alcohol production and trade, as well as in retail, advertisement and social media, to contribute to the elimination of marketing and sales of alcoholic beverages to minors and targeted commercial activities towards other high-risk groups.

WFA hopes to be able to leverage its expertise in global marketing communications to provide relevant insight, data and perspectives in relation to alcohol advertising and promotional activities including cross-border and digital marketing, minors' exposure to alcohol marketing and the role of social media.

Some top line considerations

- Alcohol marketing represents a small fraction of global marketing spend. Nielsen reports this to be 1-2% of total ad spend in countries such as UK, Netherlands and Germany.
- "Cross-border marketing" is not generally a term or concept used by the media or marketing industry. In fact, "overspill" from the area or demographic to which the marketing is targeted is, more often than not, considered wasted marketing dollars.
- The large majority of alcohol marketing is designed and distributed locally in order to meet local cultural sensitivities and norms, local product availability and in order to be compliant with local rules and regulations.
- When sporting or cultural events are broadcast internationally, on TV for instance, rights holders still sell advertising locally in order to maximize commercial opportunities.
- The increasing migration of marketing communications from traditional to digital media does not mean all advertising can be seen from anywhere. Owing to the abundance of available data online, digital marketing communications are targeted to audiences in a given location. Alcohol marketers reported they nearly always "geo-block" their marketing communications to avoid "overspill".

- The same data allow marketers to be more precise than ever before in avoiding audiences under the legal drinking age. Existing audits using avatar technologies show minors' assumed exposure to online alcohol marketing to be very small, equivalent to 0.1% of all ads seen. Studies measuring minors' exposure on other media, such as TV, show minors' exposure to be in decline.
- Social media platforms have developed an increasingly sophisticated suite of technologies to offer greater choice to users who want to opt out of ads and ensure that minors are not exposed to alcohol marketing communications.

We welcome the opportunity to discuss any of the issues raised in this submission. Please contact Will Gilroy, Director of Policy and Communications, WFA (w.gilroy@wfanet.org).

Attachment(s): 1

00320_03_wfa-submission-to-who-consultation-dec2020.pdf

Cross-Border Alcohol Marketing Communications:

What do we mean by cross-border marketing and what is the size of ‘the problem’?

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I. Contextualizing Alcohol Marketing

What proportion of all marketing communications spend is for alcohol products?

Nielsen reports that in the UK alcohol marketing constitutes 1% of total marketing communications spend. In the Netherlands and Germany, alcohol marketing makes up 2% of total marketing spend. Data from these three countries suggests that most alcohol marketing spend goes to cinema, outdoor, and television advertising. However, while these figures take into account online

advertising, they do not include advertising on all social media, namely behind the ‘walled gardens’ of the likes of Facebook, as this cannot be measured by Nielsen.

Media agencies, including GroupM and Zenith, are currently working on building comprehensive data sets for all product categories which promise to offer an accurate and holistic figure of alcohol spend which includes spend across all digital media.

While we expect these data sets to be available in early 2021, WFA estimates from various sources (including [Ad Age data Centre](#)) that global marketing spend by the alcohol industry is roughly \$US22bn, which tallies with the above-cited figures since Zenith estimates total global marketing communications spend *across all sectors and industries* to be roughly \$1 trillion.

It is worth noting then the statement in the WHO EURO 2020 report [Alcohol marketing in the WHO European region](#) that global marketing communications spend for alcohol products amounts to a trillion dollars is highly misleading; total global marketing communications spend across *all* sectors is estimated to be at \$1 trillion. While a new version of the report no longer includes this figure, it has already been quoted numerous times by academics, health officials and civil society organizations, most recently during a webinar on alcohol marketing which was attended by officials from the European Commission.

What proportion of marketing budgets are spent online and on social media platforms?

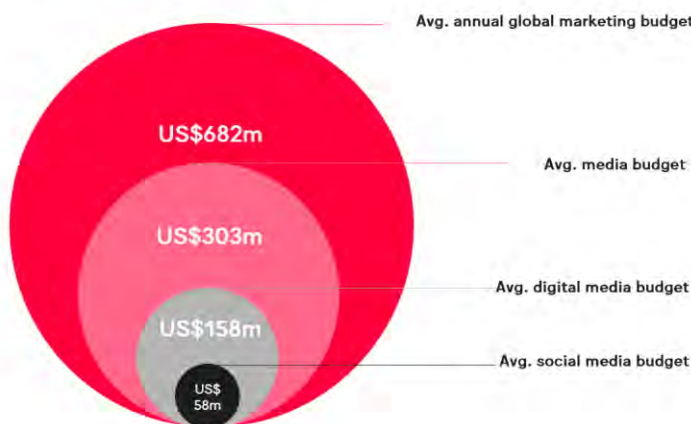
In July 2020, WFA conducted a survey among IARD and WFA members in the alcohol sector to gain insight into alcohol marketing practices. Seven of the largest alcohol companies responded to the survey. While this is not a complete overview of all alcohol company practices, the seven respondents represent the three sectors (beer, wine and spirits), are a mix of both larger and smaller companies, collectively manage over 700 brands across 200 markets, and thus are a representative sample of the wider industry.

The seven respondents’ marketing budgets varied from less than US\$250m to US\$2bn but averaged US\$682m.

What is your estimated total annual global marketing budget?



Average marketing spend figures from our sample of respondents



Of the seven respondents, four estimated that less than US\$250m of their marketing budgets were allocated to media. This is the amount allocated to above the line marketing, in other words, advertising that will be sent around to a wider audience such as television, radio, and social media. Remaining marketing spend is allocated to what is known as ‘below-the-line’ marketing, such as branding, sponsorship, printed materials, trade show appearances, sampling and more.

When it comes to allocation of media budgets, again the figures vary with some companies spending as little as 16-20% online and others spending over 50% of their media budgets on online media.

Of the total global digital media budget, respondents reported an average of 37% going on social media.

II. “Cross-border marketing”

Cross-border marketing is not an industry term or concept

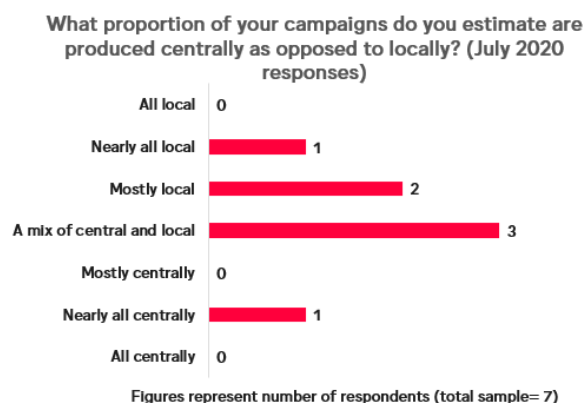
The WHO working document describes the cross-border marketing of alcohol as an area of deep concern. However, cross-border marketing is not a term typically used and understood by the media and marketing industry.

“Cross-border marketing is not a term typically used by the industry. Rather it flies in the face of conventional marketing wisdom. While campaigns are often developed for multiple countries, each country will be allocated its own budget and performance targets. Marketing dollars that do not contribute to brand awareness or activations in a specified target audience and location are considered wasted, something which all marketers are under great pressure to avoid,” says Jonathan Barnard who is Head of Forecasting and Director of Global Intelligence at Zenith, a leading media agency.

Typically, multinational advertisers will have global marketing and media budgets which are allocated to local marketing and media teams with the objective of reaching local consumers. This applies to all forms of advertising, including TV and online advertising.

In a survey of WFA members on transparency in global production conducted in January 2020, there were four alcohol company respondents. One company said 60-70% of their campaigns were produced locally, another 70-80%, another 80-90% and another over 90%.

The remainder, representing centrally produced campaigns, will still require (often significant) local adaptation for local distribution in local markets.



This figure is corroborated by our July 2020 survey which found that six out of seven respondents said their campaigns are either a mixture of local and global, mainly local or nearly all local. Only one respondent said their campaigns were nearly all produced globally and only one said they would not adapt the campaign to the local market.

Marketers need to consider local retail, cultural and linguistic environments when developing campaigns, and, more than nearly any other sector, alcohol brands also need to consider and navigate a myriad of different regulations.

So, the vast majority of advertising and marketing is local, particularly when it comes to something as culturally specific as alcohol. Marketing needs to speak to people in a local context in light of the local availability of products and services; it needs to be framed through the lens of local cultural sensitivities and local rules (particularly when it comes to alcohol) mean marketers must ensure campaigns meet local societal and regulatory expectations.

For these reasons, ad campaigns need to be developed with local audiences in mind. More than one marketer in our enquiries mentioned that advertising that is not seen by your target audience (be that in the wrong location or of the wrong age group) is considered to be wasted marketing spend, something marketers are under enormous pressure to reduce.

Nevertheless, given the increasingly connected world we live in and the rise of “global digital media”, it is easy to imagine that ad campaigns can be ‘global’ or at least ‘multi-national’. Digital (online) marketing communications (including social media), linear and non-linear television and e-games can all have multi-national reach.

III. Advertising is largely ‘local’

Brian Wieser, Global President, Business Intelligence at GroupM, the media buying arm for the world’s largest advertising services company is often referred to as Madison Avenue’s de facto chief economist¹. He explains how advertising remains largely local:

“Even though brands and social media platforms may be global, marketing is still by and large conducted locally. For the world’s larger marketers, profit and loss statements (P&Ls) and key performance indicators (KPIs) are typically managed locally, usually at the country level. Something as culturally specific as alcohol means alcohol marketers will be especially careful to only market products to a very specific audience in a very specific location. The social media platforms actually enable this through better segmentation and geo-blocking. As such, the concept of conducting cross-border marketing is counter-intuitive and largely something marketers try and avoid as it can be considered a waste of ad dollars. There can be exceptions, such as with marketing through airport channels or on pan-regional TV networks where the concept of borders may have less practical meaning.”

A. Digital

Online ad spend across all sectors accounted for 47% of total ad expenditure globally in 2019, according to Zenith, a share that is expected to increase to 52% in 2021². That said, as indicated above, the vast majority of this spend will be on local rather than international activation.

The vast amount of online spend by alcohol companies will be restricted to specific geographies owing to the need to abide by local rules and product availability. Online, marketers are able to target people based on their location, with ads that are tailored to that region. This is the preferred method of reaching potential consumers, for the linguistic and cultural reasons mentioned above. In our July 2020 research, six out of seven respondents said that “all” or “nearly all” their marketing content was geo-blocked to ensure it is not visible to consumers in countries with different cultural or legal requirements.

B. Television

On TV, most channels offer local feeds. International channels such as Disney or MTV adapt their programming and advertising to suit local markets. This means advertising on these channels caters to local audiences. On these channels, an estimated 95% of ad revenue comes from local advertising and the remaining 5% from multi-market campaigns, but where spots are still localised for the markets in which they run.

For channels like CNN or BBC Worldwide the share of revenue from pan-regional campaigns (as opposed to local) will be higher, as they just have one feed across regions. WFA understands that the categories that invest most in the pan-regional advertising market are travel, luxury, energy and corporate marketing.

IV. What proportion of ads that people see are for alcohol products?

The working document calls for dialogues with economic operators in alcohol production and trade to aim for implementation of comprehensive restrictions or bans on traditional, online or digital

¹ <https://www.groupm.com/author/brian-wieser/>

² <https://www.zenithmedia.com/internet-advertising-will-exceed-half-of-global-adspend-in-2021/>

marketing (including sponsorship). However, economic operators are already taking concrete steps towards eliminating the marketing and advertising of alcoholic products to minors.

[Latest figures](#) from the Advertising Standards Authority (ASA) in the UK show that 0.8% of all TV ads seen by minors in 2019 were alcohol ads. This percentage has remained below 1% since 2015. Between 2008 and 2019 children's exposure to TV alcohol ads decreased by two thirds, from an average of 2.8 to an average of 0.9 ads per week.

While this decline in exposure to alcohol ads on TV can in part be explained because of a decline in TV viewing among children, the report finds that children's exposure to TV ads for alcohol is falling at a faster rate than their exposure to all TV ads.

ASA research on online advertising indicates similarly low results. In 2019, the ASA used avatar monitoring technology to give insights into the current context of online display age-restricted ads in the UK. The research was conducted by Nielsen and used 'avatar' profiles which mimicked the behaviour of users representing different ages (children, teenagers, adults) and captured which ads were shown to the different age groups online. The [study](#) found that less than 0.1% of all ads viewed by the avatars were for alcohol beverages. The monitoring did not identify any instances where alcohol ads were served to child avatars on websites clearly intended for children.

Inspired by the same methodology employed by the advertising regulator in the UK, WFA commissioned Nielsen to conduct similar research in September 2020, across 12 different countries (Australia, Brazil, Canada, Czech Republic, Denmark, France, Germany, Ireland, Japan, Singapore, South Africa, Spain) to see if the UK figures are replicated in different geographies.

Of the over half a million ads Nielsen's servers captured during this period across the 12 countries, only 597 were for alcohol, amounting to only 0.11% of all ads captured.

Nielsen's findings indicate that a child or teenager would need to visit an average site 1,086 times before being served an alcohol ad. Furthermore, Nielsen found no evidence that the underage avatar profiles had been targeted by alcohol advertisers.

What protections for minors are already being undertaken by digital platforms?

The working document highlights digital marketing and social media as areas which are not easily subjected to national-level control. However, social media platforms offer increasingly robust controls to advertisers to ensure that they do not market to minors.

None of the biggest social media platforms (Facebook, YouTube, Instagram, Snapchat, Twitter) allow advertisers to target users who are under the local legal purchase age for alcohol. The main platforms do not allow alcohol advertisers to place ads in countries where alcohol advertising is banned, and all ads must abide by local restrictions. For example, a Facebook user in Lithuania (where all forms of alcohol marketing are banned) would not be served alcohol ads on the platform.

These platforms offer very specific localised targeting, allowing advertisers to reach users in a given state or even city. Facebook's [alcohol advertising policy](#) reminds advertisers that different regions have different age targeting requirements, such as the example of India, where different states have different legal purchase ages. Facebook also allows users to opt out of receiving alcohol ads and this is a principle WFA is exploring with other social media platforms. More recently, [YouTube announced](#) a similar feature will be available on Google Ads and YouTube in early 2021.

Snapchat, a platform popular among younger audiences, also has safeguards in place to prevent minors from seeing alcohol ads. [This video](#) shows an example of how advertisers can target ads based on a user's age on Snapchat, in order to avoid those under the legal purchase age. TikTok, another platform popular with young audiences, does not allow any alcohol advertising on the platform as most of their users are under the legal purchase age (though data from TikTok suggests this is rapidly changing as more adults move to the platform).

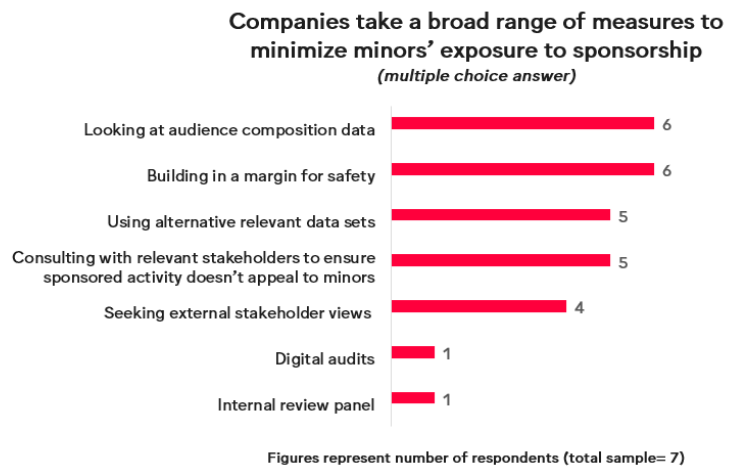
Sponsorship

WFA's July 2020 research showed that on average companies allocate 22% of their global marketing budget to sponsorship but responses varied widely between companies.

Companies take a wide variety of measures to ensure that their sponsorship assets do not appeal to minors. Six out of seven respondents said they look at the composition of the audience to ensure that at least 70% of the audience is over LPA and build in a margin for safety to ensure they go above and beyond legal and self-regulatory requirements for minimizing minors' exposure to alcohol marketing.

Five out of seven look at alternative relevant data sets to see that the assets are not appealing to minors and consult with relevant stakeholders to ensure the activity/ individual /event/etc. sponsored is not primarily appealing to minors.

Four out of seven systematically seek external stakeholder views on their sponsorship activities to ensure they are aligned with societal expectations in terms of minimizing minor's exposure to alcohol marketing communications. Finally, two in seven took other measures, including conducting digital audits, internal communications committees and panels who review sponsorship assets, etc.



eCommerce

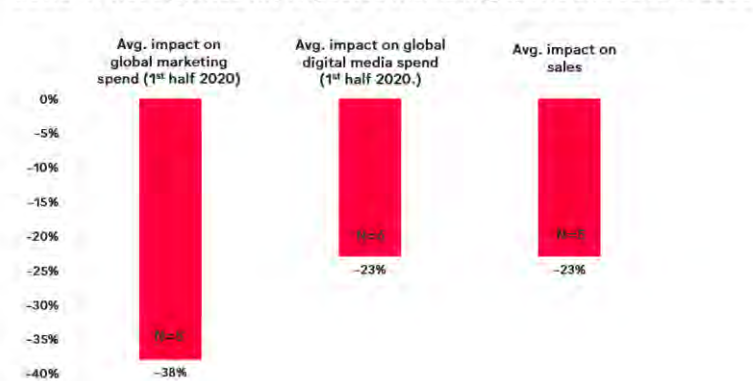
For all the talk of eCommerce, it still represents a relatively small percentage of sales for the alcohol sector. In our July 2020 survey, four respondents said eCommerce represented 5-10% sales while another two claimed it represented 11-15% (one did not respond). Growth is naturally expected but predictions vary wildly. One company expects sales growth in eCommerce still to be under 10%, two companies expect eCommerce to represent an increase in 11-15%, one company expects to see a rise of over 30% and another over 40%.

Companies are taking a wide variety of measures to ensure minors are not able to purchase alcohol beverage products from eCommerce sites. Five out of six respondents said they ensure that the sites apply age verification at the point of purchase, four said they ensure ecommerce platforms only work with couriers who commit to deliver alcohol to a customer after checking the customers' ID and the same number said they work with ecommerce platforms to take action to strengthen their controls, such as data cross matching.

The impact of COVID-19

COVID-19 has had a huge impact on global alcohol marketing and sales. Estimating marketing spend for the first half of 2020, four out of five respondents to this question in WFA's July 2020 survey estimated a decrease of over 21%. Two estimated a decrease of 21-40%, one estimated a decrease of 41-60% and another of over 60%. Only one company said their marketing spend was flat year-on-year for H1 2020.

Covid-19 has significantly impacted marketing spend and sales in 2020



Looking at the full year media and marketing budgets, respondents predicted an average decrease of 23% for 2020.

In terms of digital media spend all respondents estimated a decrease (with the exception of one 'don't know' response). One respondent predicted a decrease of 1-10%, one 11-20%, two at 21-40% and one at 41-60% making the average predicted decrease in global digital media spend to be about 23% for H1 2020.

This is in line with other industries. WFA members from various sectors including energy, beauty, healthcare, and finance reported an average decrease in media budgets of 36%.

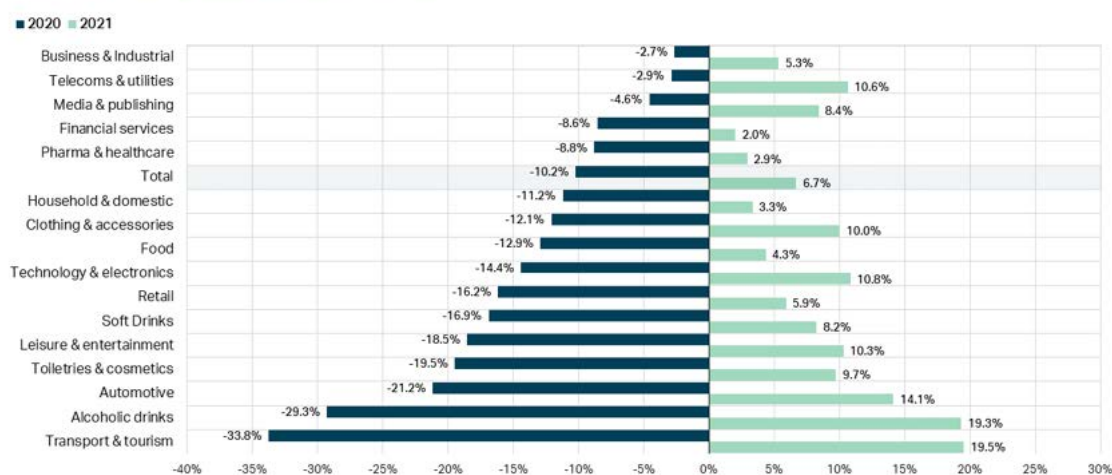
When it comes to impact on sales, four out of five alcohol company respondents predicted a negative impact on sales of 16-30%.

It is important to note that inferring a causal relationship between a decrease in sales and a decrease in marketing spend would be a highly misleading interpretation of these two sets of data. With most outlets closed, there is little incentive to compete for sales through marketing. In parallel, in times of recession when there is significant pressure to make savings, marketing is usually one of the easier budgets for a company to cut.

These marketing spend figures from our survey are corroborated by independent data from The World Advertising Research Centre (WARC) which state that alcohol advertising investment decreased by 29% in 2020. The only industry which experienced a more significant decrease is transport and tourism (-34%).

Global, Advertising investment forecast

Year-on-year % change, US\$ Nominal



Note: Data are net of discounts, include agency commission and exclude production costs.

SOURCE: WARC Data, Nielsen Ad Intel, Global Ad Trends: State of the Industry 2020/21

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We welcome the opportunity to discuss any of the issues raised in this submission.

Please contact Will Gilroy, Director of Policy and Communications, WFA (w.gilroy@wfanet.org).

World Heart Federation

Country/Location: Switzerland

URL: <https://www.world-heart-federation.org/>

Submission

The World Heart Federation will get involved more formally in 2021 as we are in the process of developing a policy brief on alcohol and CVDs and we hope that other consultations will be organised. In the meantime, we would be grateful if the WHO could define the role of the economic operators in the area of alcoholic beverage production and trade within the 2010 WHO Global Alcohol Strategy and explain, based on evidence, why dialogues with representatives of economic operators in the area of alcoholic beverage production are necessary.

Attachment(s): 0

WORLD MEDICAL ASSOCIATION

Country/Location: France

URL: <https://www.wma.net/>

Submission

We welcome WHO consultation on its working document for developing the global alcohol action plan and acknowledge the efforts made to develop a comprehensive framework encompassing all stakeholders concerned to tackle the alcohol burden weighing on public health and ultimately on health systems. We believe however that a more concise action plan would bring more clarity to the document.

We support the observation in the introduction section to the action plan recognizing that “limited technical capacity, human resources and funding hinder efforts in developing, implementing, enforcing and monitoring effective alcohol control interventions at all levels” and call for Member States to adequately fund WHO’s work on alcohol.

In our opinion, the absence of specific review and reporting mechanism for the action plan’s implementation weakens its prospective impact. We recommend that a report to the World Health Assembly be made biennially to assess the progress made, as is the case with the tobacco status report.

We share the overall analysis of the challenges identified in implementing the Global Strategy. We note however a lack of consistency between those challenges and the actions proposed under the six areas of the action plan. We believe that a successful strategy to address the harmful use of alcohol requires stronger and more tangible commitments and actions in the following areas:

1. Placing health equity at the core of the action plan;
2. Health professionals as partners in combatting the harmful use of alcohol;
3. Protecting public health interests from commercial interference;
4. The need for legally binding regulatory instruments at national and international levels.

Attachment(s): 1

00222_33_wma-comments-on-who-working-document-on-global-alcohol-action-plan-december-2020.pdf



**WHO Working document for the development of
an action plan to strengthen the implementation of the
Global Strategy to Reduce the Harmful Use of Alcohol**

WMA COMMENTS

The World Medical Association (WMA), the global federation of Medical Associations representing the millions of physicians worldwide, has a [long-standing commitment](#) towards the reduction of the harmful impact of alcohol on health and society and actively supported the adoption of WHO Global strategy to reduce the harmful use of alcohol in 2010. Alcohol consumption constitutes a major trigger for Non-Communicable Diseases (NCD), communicable diseases, violence, and injuries and we note with great concerns the limited progress made to reverse the current trend since 2010.

General comments

We welcome WHO consultation on its working document for developing the global alcohol action plan and acknowledge the efforts made to develop a comprehensive framework encompassing all stakeholders concerned to tackle the alcohol burden weighing on public health and ultimately on health systems. We believe however that a more concise action plan would bring more clarity to the document.

We support the observation in the introduction section to the action plan recognizing that “*limited technical capacity, human resources and funding hinder efforts in developing, implementing, enforcing and monitoring effective alcohol control interventions at all levels*”¹ and call for Member States to adequately fund WHO’s work on alcohol.

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We share the overall analysis of the challenges identified in implementing the Global Strategy. We note however a lack of consistency between those challenges and the actions proposed under the six areas of the action plan. We believe that a successful strategy to address the harmful use of alcohol requires stronger and more tangible commitments and actions in the following areas:

¹ 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, p.5

1. Placing health equity at the core of the action plan

We welcome the point raised in the introduction section of the working document on the “*disproportionate prevalence of effective alcohol control measures in higher-income countries*”, raising questions about global health equity and agree on “*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*”². We regret that the action plan does not include more tangible actions to meet this requirement.

More generally, we recommend a stronger emphasis on health equity by placing it at the core of the action plan. Social, cultural, environmental and economic factors are major determinants on the quality of life, good health and life expectancy and have decisive impacts on alcohol consumption patterns.

Addressing the problematic of alcohol through a Social Determinants of Health (SDH) perspective requires looking at the root causes of alcohol behaviours. This is essential for the understanding of the problem and makes it possible to unveil health inequities which are often the primary source of addictive patterns and other alcohol abuses.

We believe therefore that it is critical that health inequities are clearly identified in the action plan as major sources of alcohol abuses. This would underscore the ethical and human rights principles as the founding values of the plan, beyond the health costs of the scourge.

2. Health professionals as partners in combatting the harmful use of alcohol

We welcome the actions proposed in the plan for the attention of health professionals, mainly related to capacity-building and education, but regret that their role in documenting and preventing alcohol abuses is not further developed. We note a clear disparity between the overwhelming consideration given to economic operators in the action plan compared to health professionals³. This variance seems to us particularly inadequate from a public health perspective.

Physicians and other health professionals play a key role in education, advocacy and research. Physicians in particular work to reduce the harmful use of alcohol by identifying early-stages of addictive behaviour in consultations with their patients and supporting them in changing behaviour in the framework of a trustworthy patients-physicians relationship. They can promote evidence-based prevention strategies in schools and communities and assist in informing the public of alcohol related harm. Physicians also have an important function in facilitating epidemiologic and health service data collection on the impact of alcohol with the aim of prevention and promotion of public health.

We believe that those considerations are not sufficiently reflected in the proposed action plan and recommend its revision so that health professionals are considered as recognized partners in tackling the alcohol affliction.

² 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, p.2

³ See below, item 3

3. Protecting public health interests from commercial interference

The working document identifies as one of the challenges in implementing the strategy “*the influence of powerful commercial interests in policy-making and implementation (...) 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*”. “*General trends towards deregulation in recent decades have often resulted in a weakening of alcohol controls, to the benefit of economic interests and to the expense of public health and welfare*”⁴.

We welcome this accurate analysis of the situation. Unfortunately, the conclusions are not followed by tangible actions later in the plan. The structure of the action plan includes an explicit role for economic operators suggesting that their contributions are authentic. Under each area of the plan, actions to the attention of economic actors are proposed with a view to *contribute to* the reduction of alcohol burden or to *refrain* from acting against public health interests. We cannot validate those proposals that we consider inappropriate, unrealistic and even dangerous, leaving the door open to commercial intrusion to the very detriment of public health.

Equally, we have strong reservations on the validity to pursue a regular “global dialogue” with the alcohol industry⁵, which counteracts the Guiding principle 1 (Global Strategy to Reduce the Harmful Use of Alcohol. WHO, 2010): “*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*”.

The role of the alcohol industry in the reduction of alcohol-related harm should be strictly confined to their roles as producers, distributors and marketers of alcohol, and never include alcohol policy development or health promotion. It is crucial that the action plan sets very clear boundaries on the scope of action of the alcohol industry to protect public health interests.

Furthermore, we are concerned to note that the responsibility for monitoring and reporting interference from commercial interests lies only with civil society actors. We strongly recommend providing the plan with a comprehensive monitoring mechanism led by the WHO secretariat involving all actors, including Member States, to counter commercial intrusions.

Commercial interests contradict the very essence of the strategy to serve public health. We identify no evidence of efficacy for continuing dialogue with the alcohol industry and deeply regret the disproportionate attention given to economic operators in the plan, compared to the limited consideration provided to the health professionals’ role in documenting and preventing harmful use of alcohol⁶.

4. The need for legally binding regulatory instruments at national and international levels

In the challenges identified, the working document refers to the absence of legally-binding regulatory instruments which “*limits the ability of (...) 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. This prompted calls for a global normative*

⁴ 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, p.4

⁵ Action area 3: partnership, dialogue and coordination, p.16

⁶ See above, item 2

law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control”.

Regretfully, the actions recommended later in the plan to the attention of Member States do not effectively address those challenges. Yet, the “best buys”, promoted by WHO-led SAFER initiative, are recognised as the most cost-effective policy measures for alcohol control⁷. Alcohol is responsible for significant mortality and morbidity around the world and it is time for governments to take their responsibilities. We recommend a more ambitious action plan including pertinent regulatory and fiscal measures to reduce harmful alcohol consumption, such as:

- Effective restrictions on advertising;
- Setting a minimum unit price at a level that will reduce alcohol consumption;
- Regulation of access to, and availability of, alcohol by limiting the hours and days of sale, the number and location of alcohol outlets and licensed premises, and with a minimum legal drinking age.

To protect alcohol control measures, we further recommend that alcohol be classified as an extraordinary commodity and that measures affecting the supply, distribution, sale, advertising, sponsorship, promotion of or investment in alcoholic beverages be excluded from international trade agreements. Health impact assessments of trade agreements constitute a necessity to protect, promote and prioritize public health over commercial interests.

Finally, we support the proposal made in the introduction of the action plan to open discussion on a global normative regulation of alcohol at intergovernmental level, modelled on WHO Framework Convention on Tobacco Control.

07.12.2020

⁷ 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, p.2

World Spirits Alliance

Country/Location: Belgium

URL: <https://www.worldspiritsalliance.com/>

Submission

The World Spirits Alliance (WSA) is an international trade association dedicated to representing the views and interests of the spirits sector at the international level.

In response to the publication of the working document on the Global Strategy to Reduce the Harmful Use of Alcohol, see below a broad outline of our main comments:

- 1) A more stringent methodological differentiation between the concepts of harmful use of alcohol and per capita consumption of alcohol is needed
- 2) The narrow focus on 'one-size-fits-all' universal policy approaches such as the SAFER initiative package is inconsistent with the flexible menu of policy options provided for in the GAS
- 3) COVID-19, unwanted consequences of overly restrictive policy approaches
- 4) Alcohol producers and relevant private sector actors are important stakeholders in the broader policy dialogue on how to reduce the harmful consumption of alcohol

We invite you to read the attached document to have a more complete understanding of our comments.

We thank the WHO for providing us with this opportunity to give our views. We would also be happy to provide any additional information needed.

Attachment(s): 1

00348_21_wsa-047-2020-wsa-submission-to-the-who-gas-consultation-december-2020-final.pdf



The World Spirits Alliance (WSA) Response to the Global Alcohol Strategy (GAS) Consultation

December 2020

The World Spirits Alliance (WSA) is an international trade association dedicated to representing the views and interests of the spirits sector at the international level.

WSA and its members are fully committed to responsible production, advertising and marketing of distilled spirits and encouraging adults who choose to consume spirits, to do so responsibly and in moderation. We acknowledge that beverage alcohol products can be abused and fully support the public health objective of combating the harmful consumption of alcohol.

Given the global reach and representativeness of our association, we welcome the opportunity to participate in this consultation of the Global Alcohol Strategy (GAS), and we consider this as a valuable occasion to provide comments and proposals on relevant policy approaches currently discussed by the World Health Organisation (WHO). We are convinced of the inherent usefulness of taking a whole-of-society approach to reduce the harmful consumption of alcohol and believe in the fundamental importance of continuing such broad dialogues (like the current consultation) in the future.

In response to the publication of the working document on the *Global Strategy to Reduce the Harmful Use of Alcohol*, we would like to share the following views and comments:

1) A more stringent methodological differentiation between the concepts of harmful use of alcohol and per capita consumption of alcohol is needed

- The document blurs the lines between the concepts of harmful use of alcohol and per capita consumption which is methodologically questionable and does not reflect the GAS' focus on reducing the harmful use of alcohol. This shift in focus from the harmful use of alcohol to per capita consumption contradicts not only the GAS but also the Member State endorsed 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.
- Also, with regards to trend analyses, it is important to underline that levels of per capita alcohol consumption may sometimes remain stable or decrease only slightly, while harmful consumption is declining at a much faster rate. A correlation between alcohol consumption and harmful alcohol consumption is further weakened when the affluence or wealth of the society is considered; as stated in the report, wealthier regions consume



more alcohol, but these regions are not necessarily those with the highest rates of *harmful* consumption of alcohol.

2) The narrow focus on ‘one-size-fits-all’ universal policy approaches such as the SAFER initiative package is inconsistent with the flexible menu of policy options provided for in the GAS

- Trends in alcohol consumption tend to vary greatly across different continents and countries. Therefore, the WSA believes that all parties should be empowered to choose from a broader menu of options to tackle harm as outlined in the Global Strategy and other proven interventions, rather than taking a narrow focus on a very limited number of policy measures. This will ensure that alcohol-related harm can be most efficiently and effectively addressed within its specific local contexts, also taking into account relevant economic, social, cultural and religious circumstances.
- The working paper focuses on a narrow set of policy initiatives in the WHO’s SAFER initiative which is not a Member State endorsed document and does not reflect the menu of policy options provided for in the Member State endorsed GAS. The SAFER initiative contains certain policies – some of which are unsuited to affluent, highly-regulated policy environments, while others may have unintended negative consequences in less affluent societies. In affluent, highly regulated countries, for instance, increases in the price of alcohol, or reductions in the availability of alcohol, have been shown to disproportionately impact moderate drinkers, but less so on those more likely to drink alcohol to a harmful level. However, risky drinkers may revert to alternative sources for alcohol. Increases in excise tax rates have often been accompanied by spikes in the consumption of illicit or unrecorded alcohol, a consumer practice which is “associated with significant health risks and challenges for regulatory and law enforcement sectors of governments” in this report.
- Particularly in less affluent society settings, illicit trade does undermine economic activity, deprives governments of necessary revenues for investment, and exposes consumers to health risks. Unregulated alcohol is mainly prevalent in lower-income countries and contributes to an important share of harmful drinking. Policies to curb harmful drinking in these countries cannot be the same as those in highly regulated

regions. In addition, illicit alcohol can be divided into many different categories, which all require different strategies to be tackled. The WSA believes that the reduction of illicit trade should be a key area of focus of the Global Alcohol Strategy.

- In terms of taxation, the document not only makes several references to increasing taxes on alcohol beverages, but it also calls for earmarked taxation on alcohol beverages to fund prevention and treatment of alcohol use disorders. It proposes a target for increasing the number of countries that have earmarked tax revenue for reducing the harmful use of alcohol. However, the working paper does not reference the WHO's own arguments against such earmarked taxes, which include economic distortion and budgetary inflexibility.
- In the past, earmarked policies have proven inefficient and counterproductive. In 2015 in Thailand, a 2% sports tax on the amount of the excise tax was levied on alcoholic beverages and tobacco products. Revenues from the sports tax were deposited in a Sports Fund". These earmarked taxes were intended to finance special funds or initiatives which are not regulated by the general tax law and the administration of these taxes was unclear and non-transparent. This case example shows how certain policies proposed by the working document cannot be implemented correctly worldwide and can instead lead to counterproductive results.

3) COVID-19, unwanted consequences of overly restrictive policy approaches

- The document tentatively suggests that consumption has increased during the pandemic based on incomplete and flawed evidence of an increase during the early stages of the pandemic among some population segments. The report argues that the pandemic has underscored the importance of developing appropriate alcohol related policy responses during public health emergencies, but it does not draw conclusions about COVID-related alcohol policies.
- During Covid-19, several governments throughout the world have temporarily put in place drastic measures with a view to reducing the availability alcohol, measures which have sometimes proven to be highly ineffective and even counterproductive. South Africa is one such example by having followed a highly restrictive approach with regards to alcohol and imposing a ban on the sales and distribution of alcohol. This



South African approach has been accompanied by several unwanted consequences for the health of consumers. The ban on South Africa turned consumers to illegal markets and has fuelled underground trade. The illegal manufacture of alcoholic concoctions poses serious health risks. The increase in demand for illicit products was evidenced by the 200% increase in pineapple prices due to the demand for homemade brew. Yeast was also out of stock in most grocery stores and licensed liquor outlets were looted. In addition, illegal products were sold at double to triple the normal price diverting much needed income and making criminals out of ordinary people. The South African case points out the risks and inefficiencies of overly restrictive policy approaches. The lessons to take from the South African experience are also that a legal alcohol industry is a more economically efficient force against illicit activities.

4) Alcohol producers and relevant private sector actors are important stakeholders in the broader policy dialogue on how to reduce the harmful consumption of alcohol

- This report notes that alcohol is not subject to a framework convention – a proposal in this regard was not supported at the very World Health Assembly where the roadmap on this Global Strategy was agreed. Furthermore, the report warns against the involvement of the private sector in the development of policy. This is inconsistent with the High-Level Political Declaration on NCDs (2018) which “encourage[ed] economic operators in the area of alcohol production and trade, as appropriate, to contribute to reducing harmful use of alcohol in their core areas”¹
- The marketing and advertising of alcohol are already highly regulated in many countries across the world. Our sector has worked extensively with government actors around the world and with the WHO to discuss further regulation as well as appropriate self- and co-regulatory measures and commitments to raise standards for advertising and marketing, and seek to reduce the exposure of certain groups (minors, problem drinkers) to alcohol advertising. For this, and also taking into account technological changes in recent years,

¹ Political declaration of the 3rd High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases
<https://digitallibrary.un.org/record/1648984?ln=en>



dialogue, cooperation and regular exchanges with the private sector are indispensable – **seeking the exclusion of alcohol producers and other economic operators would go against such an approach.**

We would like to thank the WHO for taking into account the above points and are happy to provide additional information on them as and when required.

Worldwide Brewing Alliance

Country/Location: Switzerland

Submission

The Worldwide Brewing Alliance (WBA), an association of national and regional brewers' trade associations and brewers whose members together represent the producers of nearly 90% of the world's supply of beer, appreciates this opportunity to share its views on the working document. We attach a formatted version of these comments, including links to citations, for easier reading.

1. The Working Document missed the opportunity to incorporate evidence that recommends using alcohol policies to nudge consumers toward lower alcohol strength options as an effective and cost-effective way to reduce harmful consumption of alcohol.

Current evidence supports the practice of using alcohol policies to nudge consumers toward lower alcohol strength choices. Policies in the WHO's SAFER technical package that affect pricing, availability, and marketing of alcoholic beverages – that is, those which are promoted as the most cost-effective – are commonly designed to influence consumer choice in order to reduce alcohol-related harm. The Working Document is missing this layer of evidence-based best practice with respect to these alcohol control policies, which should be integrated into the Global Strategy action plan, nudging consumers by policy design and implementation. The evidence base establishes the public health interest in steering consumers toward lower alcohol products.

i) The effects of alcohol consumption depend on what you drink and how you drink it.

Alcohol policies should nudge consumers toward lower-alcohol beverages because the evidence shows that these beverages are less correlated with some of the most dangerous types of harmful drinking.

The evidence supports the common-sense recognition that rapid consumption of highly concentrated alcohol creates a greater risk for outcomes like alcohol poisoning and accidents:

"Alcohol-attributable burden of disease is usually calculated under the assumption that beverage type does not matter; risk relations are based on level and pattern of use of pure alcohol (ethanol) rather than differentially by beverage type. ... However, this assumption is challenged by many ecological studies, which point to a higher impact of spirits consumption compared to the same ethanol content in the form of beer or wine." Rehm, Jürgen, and Omer SM Hasan. "Is burden of disease differentially linked to spirits? A systematic scoping review and implications for alcohol policy." *Alcohol* 82 (2020): 1-10.

"[W]e find that the type of drink consumed is quantitatively at least as important as the amount of alcohol consumed. This is because most alcohol-related deaths of working-age adults – fatal traffic accidents, homicides, suicides, and fatal alcohol poisoning – are a consequence of binge drinking." Kueng, Lorenz, and Evgeny Yakovlev. "The Long-Run Effects of a Public Policy on Alcohol Tastes and Mortality." Available at SSRN 2776422 (2019).

"[D]istilled spirits consumption is a major factor of adult male mortality, with a significantly greater impact compared to beer and wine. This must be due to higher alcohol concentration leading to higher rates of intoxication. Therefore, the reduction in distilled spirits consumption in hard liquor drinking

areas should be a major target in health policy.” Korotayev, Andrey, et al. "Distilled spirits overconsumption as the most important factor of excessive adult male mortality in Europe." *Alcohol and Alcoholism* 53.6 (2018): 742-752.

These important insights do not imply that consuming higher ABV drinks is always dangerous to health, or that poor health is never an outcome of overconsumption of beer or other lower alcohol products. They show that beverage type and drinking patterns influence health outcomes at the population level in ways that are not yet fully integrated into global risk assessments, or into the formal policy recommendations of the Global Strategy. The Global Strategy action plan presents an opportunity to align with current evidence and propose policies that nudge consumers by design rather than by accident.

ii) Nudging consumers toward lower alcohol products can reduce alcohol-related harm.

The evidence, which is increasingly being incorporated into national and regional alcohol policies also demonstrate that steering consumers toward lower alcohol products can reduce alcohol-related harm.

The custom of using alcohol policy levers to influence consumer choices is not new, nor is it new to the WHO. In its 2004 report on alcohol policy, the WHO identified the practice of promoting lower alcohol beverages as an effective strategy to reduce alcohol-related harm:

“[I]n some countries, the official policy of the pricing system is to steer people towards a particular type of low-alcohol or non-alcoholic beverage, in order to substantially reduce risky or high blood alcohol levels, i.e. discourage spirits drinking and encourage beverages with lower alcohol content. ... Overall, the evidence, although not conclusive at this stage, suggests that furthering beverages of lower alcohol content can be an effective strategy to reduce the level of alcohol consumed and the associated harm.” WHO, *Global Status Report: Alcohol Policy* (2004), at p.41 [Citations omitted; emphasis added.]

In practice, influencing consumer choice through taxation is carried out, for example, by applying different excise rates according to different beverage categories, as well as within categories, according to alcohol strength. This can nudge the heaviest drinkers to shift to lower-strength options, reducing harmful consumption:

“Consistently heavy drinkers ... systematically purchase a different mix of products than lighter drinkers; on average, they buy stronger and cheaper varieties of alcoholic beverages. We find that they are much more willing to switch between different alcohol products in response to price changes, and are less willing to switch away from alcohol altogether than lighter drinkers.

“By levying a relatively high tax rate on strong spirits the planner is able to target a larger share of the alcohol purchases of heavy than light drinkers, and is able to encourage them to switch to less strong alcohol products, hence lowering their level of ethanol consumption should target the drinking behaviors that are most costly to public health and society.” Griffith, Rachel, Martin O’Connell, and Kate Smith. "Tax design in the alcohol market." *Journal of public economics* 172 (2019): 20-35.

Steering consumers toward lower alcohol products has been credited with reducing harmful consumption of alcohol. In Russia, a policy environment in which beer was more accessible relative to distilled alcohol, ultimately led to a shift in drinking patterns from vodka to beer, and in turn to dramatic reductions in alcohol-related mortality. Gil, Artyom, Daria Khaltourina, and A. Korotaev. "Alcohol

consumption in Russia: affordability of alcohol, changes and effects of alcohol control policy and future prospects." Changes in alcohol affordability and availability. Twenty years of transition in Eastern Europe. Editors. Moskalewicz J, Osterberg E. Juvenes Print (2016): 18-50. This pattern and its positive effects on health mimics the success of shifted drinking patterns that had occurred earlier in Nordic and Eastern European countries:

A reduction in the prevalence of heavy episodic drinking, as well as the switch from spirits to lighter alcoholic beverages, suggests that the Russian Federation is in the process of moving away from the so-called northern European pattern of drinking, characterized by irregular heavy drinking sessions and preference for distilled spirits. . . . This shift in drinking patterns has been observed in the past in Nordic and eastern European countries such as Sweden, Finland and Poland, where it has led to favourable outcomes in alcohol-attributable harm. 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)."]

In short, nudging consumers toward lower-alcohol products is a widespread, successful practice that is also an evidence based, effective, and cost-effective way to reduce harmful use of alcohol – and it must be incorporated into the Global Strategy action plan.

2. As important stakeholders in local communities around the world, and key contributors to livelihoods, brewers can offer local insights and a global perspective.

Brewers are an important part of local communities, supporting livelihoods and listening to consumers' changing demands around the world.

Brewing is a predominantly local business, and the end-product tends to be consumed in the country where it was produced. It supports the development of rural sectors, particularly in developing countries. Brewing also supports jobs – and generates government revenue – all along its complex value chain. Brewing is known for having high employment multiplier effects. In Australia, nearly 22 additional full time equivalent jobs were created for each full time brewing job. ACIL Allen Consulting, "Economic Contribution of the Australian Brewing Industry 2018-19 from Producers to Consumers," March 2020. Among the EU28 countries, an estimated 16 jobs are added to the economy for each job in the brewing sector. Europe Economics, "The Contribution made by Beer to the European Economy – EU Report, March 2020." The brewers' impact on employment is even greater in developing countries – as in Uganda, where each job at a local brewery was estimated to support 60 jobs in the value chain. Prof. Ethan B. Kapstein, INSEAD, et al., "The Socio-Economic Impact of Nile Breweries in Uganda and Cervecería Hondureña in Honduras" (May 2009).

As predominantly local businesses that must be responsive to their stakeholders, brewers are effective contributors to a "whole-of-society" approach to reducing the harmful use of alcohol. In recent years, brewers have innovated ways to reduce the naturally low alcohol content of beer, creating lower- and no-alcohol products that are resonating with consumers. Emerging evidence indicates that the introduction of these products can lower per-capita consumption – for example in the UK, where introduction of Low and No Alcohol products has been shown to reduce consumption of heavy drinkers and younger consumers. Anderson, Peter, et al. "Impact of low and no alcohol beers on purchases of alcohol: interrupted time series analysis of British household shopping data, 2015–2018." BMJ open

10.10 (2020): e036371. Global policy recommendations should continue to incentivize the production of these products and their adoption by consumers.

The European Union has recognized the brewers' contribution of innovating new lower alcohol beer products. When the EU recently published legislation "modernizing" the structures of excise duties on alcohol and alcoholic beverages by increasing the volume of alcohol a beer can contain while still qualifying for the lower tax rates applied to low alcohol beer (from 2.8% to 3.5% ABV), it identified the specific goal of giving incentives for brewers to produce lower alcohol beer, as well as for consumers to choose low-strength drinks over stronger ones.

As alcohol policy experts have found, the "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." 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.

The success of low- and no- alcohol beer is a good example of how a "whole of society" approach to alcohol can and should work. The WHO should recognize that the brewers are important partners in reducing harmful consumption of alcohol, and have a critical role to play in creating an enabling environment for policy success.

3. Impact of the Covid-19 pandemic.

The Covid-19 Pandemic has had an unprecedented impact on the ecosystem of the beverage industry and has impacted beer most severely of all alcohol sectors. The closure of bars, restaurants, and cafés has disproportionately impacted brewers.

According to a recent study of the UK market the early pandemic saw household purchases of beer drop by 40%, whereas household purchases of wine increased by 15% as did spirits, by 22%. Anderson, Peter, et al. "Impact of COVID-19 Confinement on Alcohol Purchases in Great Britain: Controlled Interrupted Time-Series Analysis During the First Half of 2020 Compared With 2015–2018." *Alcohol and Alcoholism* (2020).

Similar data has emerged in Australia, where a study found that pandemic response restrictions caused on-trade beer sales to decrease, yet did not bring an increase of off-trade sales. 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).

A recovery from the pandemic that prioritizes lives and livelihoods should incorporate policies that nudge consumers toward beer and other low alcohol concentration beverages by design. Put simply such policies are good for recovering economies and aligned with national and global public health objectives.

* * *

Profiles of main authors cited:

(Connections to the World Health Organization are indicated in bold type in fully formatted version)

Peter Anderson: Served as regional advisor for alcohol with the European Office of the World Health Organization and directed the WHO EURO Department of Health Promotion; published 12 monographs on addictions for the European Commission and the World Health Organization. Affiliations: CAPHRI Care and Public Health Research Institute, Maastricht University, Maastricht, The Netherlands; Population Health Sciences Institute, Newcastle University, Newcastle upon Tyne, UK.

Artyom Gil: I.M. Sechenov First Moscow State Medical University (WHO Collaborating Centre on Training and Education of Health Policy-makers in Prevention and Control of NCDs), Moscow

Rachel Griffith: "Rachel is Research Director of the IFS [UK Institute of Fiscal Studies] and Co-Director of the Centre for the Microeconomic Analysis of Public Policy (CPP). She is Professor of Economics at the University of Manchester, a Fellow of the British Academy, a Fellow of the Econometric Society and a Research Fellow of CEPR. She is also President of the Royal Economic Society in 2019/2020. Rachel won the Birgit Grodal award in 2014 and was awarded a CBE in Queen's Birthday Honours 2015 for services to economic policy. Her research considers the relationship between government policy and economic performance. Her specific interests relate to empirical industrial organisation, the retail food sector, nutrition, innovation, productivity and corporate tax."

Ethan B. Kapstein: Arizona State University Centennial Professor of International Affairs, professor in the School of Public Affairs and senior director for research at the McCain Institute for International Leadership in Washington D.C., a think-tank associated with Arizona State University. He is also a visiting fellow at the Center for Global Development. He has previously held chaired positions at the University of Texas at Austin, INSEAD, and the University of Minnesota, Ethan has also served as a vice president of the Council on Foreign Relations, principal administrator at the Organization of Economic Cooperation and Development, and executive director of the Economics and National Security Program at Harvard University.

Andrey Korotaev: Head of the Laboratory of Monitoring of the Risks of Sociopolitical Destabilization of the National Research University Higher School of Economics, Moscow, Russia; Department of Risk Factor Prevention, Federal Research Institute for Health Organization and Informatics of Ministry of Health of the Russian Federation, Moscow, Russia (WHO Collaborating Centre on Health Information Systems, Health Statistics and Analysis).

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Attachment(s): 1

00011_01_worldwide-brewing-alliance-views-on-the-working-document-of-nov-2020.pdf

The Worldwide Brewing Alliance is an association of national and regional brewers' trade associations and brewers, whose members together span six continents and represent the producers of nearly 90% of the world's supply of beer.

1. The Working Document missed the opportunity to incorporate evidence that recommends using alcohol policies to nudge consumers toward lower alcohol strength options as an effective and cost-effective way to reduce harmful consumption of alcohol.

Current evidence supports the practice of using alcohol policies to nudge consumers toward lower alcohol strength choices. Policies in the WHO's SAFER technical package that affect pricing, availability, and marketing of alcoholic beverages – that is, those which are promoted as the most cost-effective – are commonly designed to influence consumer choice in order to reduce alcohol-related harm. The Working Document is missing this layer of evidence-based best practice with respect to these alcohol control policies, which should be integrated into the Global Strategy action plan, nudging consumers by policy design and implementation. The evidence base establishes the public health interest in steering consumers toward lower alcohol products.

i) The effects of alcohol consumption depend on what you drink and how you drink it.

Alcohol policies should nudge consumers toward lower-alcohol beverages because the evidence shows that these beverages are less correlated with some of the most dangerous types of harmful drinking.

The evidence supports the common-sense recognition that rapid consumption of highly concentrated alcohol creates a greater risk for outcomes like alcohol poisoning and accidents:

"Alcohol-attributable burden of disease is usually calculated under the assumption that beverage type does not matter; risk relations are based on level and pattern of use of pure alcohol (ethanol) rather than differentially by beverage type. ... However, this assumption is challenged by many ecological studies, which point to a higher impact of spirits consumption compared to the same ethanol content in the form of beer or wine." [Rehm, Jürgen, and Omer SM Hasan. "Is burden of disease differentially linked to spirits? A systematic scoping review and implications for alcohol policy." *Alcohol* 82 \(2020\): 1-10.](#)

"[W]e find that the type of drink consumed is quantitatively at least as important as the amount of alcohol consumed. This is because most alcohol-related deaths of working-age adults – fatal traffic accidents, homicides, suicides, and fatal alcohol poisoning – are a consequence of binge drinking." [Kueng, Lorenz, and Evgeny Yakovlev. "The Long-Run Effects of a Public Policy on Alcohol Tastes and Mortality." Available at SSRN 2776422 \(2019\).](#)

"[D]istilled spirits consumption is a major factor of adult male mortality, with a significantly greater impact compared to beer and wine. This must be due to higher alcohol concentration leading to higher rates of intoxication. Therefore, the reduction in distilled spirits consumption in hard liquor drinking areas should be a major target in health policy." [Korotayev, Andrey, et al. "Distilled spirits overconsumption as the most important factor of excessive adult male mortality in Europe." *Alcohol and Alcoholism* 53.6 \(2018\): 742-752.](#)

These important insights do not imply that consuming higher ABV drinks is always dangerous to health, or that poor health is never an outcome of overconsumption of beer or other lower alcohol products. They show that beverage type and drinking patterns influence health outcomes at the population level in ways that are not yet fully integrated into global risk assessments, or into the formal policy recommendations of the Global Strategy. The Global Strategy action plan presents an opportunity to align with current evidence and propose policies that nudge consumers by design rather than by accident.

ii) **Nudging consumers toward lower alcohol products can reduce alcohol-related harm.**

The evidence, which is increasingly being incorporated into national and regional alcohol policies also demonstrate that steering consumers toward lower alcohol products can reduce alcohol-related harm.

The custom of using alcohol policy levers to influence consumer choices is not new, nor is it new to the WHO. In its 2004 report on alcohol policy, the WHO identified the practice of promoting lower alcohol beverages as an effective strategy to reduce alcohol-related harm:

“[I]n some countries, the official policy of the pricing system is to steer people towards a particular type of low-alcohol or non-alcoholic beverage, in order to substantially reduce risky or high blood alcohol levels, i.e. discourage spirits drinking and encourage beverages with lower alcohol content. ... **Overall, the evidence, although not conclusive at this stage, suggests that furthering beverages of lower alcohol content can be an effective strategy to reduce the level of alcohol consumed and the associated harm.**”
[WHO, Global Status Report: Alcohol Policy \(2004\), at p.41](#) [Citations omitted; emphasis added.]

In practice, influencing consumer choice through taxation is carried out, for example, by applying different excise rates according to different beverage categories, as well as within categories, according to alcohol strength. This can nudge the heaviest drinkers to shift to lower-strength options, reducing harmful consumption:

“Consistently heavy drinkers ... systematically purchase a different mix of products than lighter drinkers; on average, they buy stronger and cheaper varieties of alcoholic beverages. We find that they are much more willing to switch between different alcohol products in response to price changes, and are less willing to switch away from alcohol altogether than lighter drinkers.

“By levying a relatively high tax rate on strong spirits the planner is able to target a larger share of the alcohol purchases of heavy than light drinkers, and is able to encourage them to switch to less strong alcohol products, hence lowering their level of ethanol consumption should target the drinking behaviors that are most costly to public health and society.” [Griffith, Rachel, Martin O’Connell, and Kate Smith. "Tax design in the alcohol market." *Journal of public economics* 172 \(2019\): 20-35.](#)

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A reduction in the prevalence of heavy episodic drinking, as well as the switch from spirits to lighter alcoholic beverages, suggests that the Russian Federation is in the process of moving away from the so-called northern European pattern of drinking, characterized by irregular heavy drinking sessions and preference for distilled spirits. . . . This shift in drinking patterns has been observed in the past in Nordic and eastern European countries such as Sweden, Finland and Poland, where it has led to favourable outcomes in alcohol-attributable harm. [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 \(2019\)."](#)¹

In short, nudging consumers toward lower-alcohol products is a widespread, successful practice that is also an evidence based, effective, and cost-effective way to reduce harmful use of alcohol – and it must be incorporated into the Global Strategy action plan

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Brewers are an important part of local communities, supporting livelihoods and listening to consumers' changing demands around the world.

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A recovery from the pandemic that prioritizes lives and livelihoods should incorporate policies that nudge consumers toward beer and other low alcohol concentration beverages by design. Put simply such policies are good for recovering economies and aligned with national and global public health objectives.

Profiles of main authors cited:

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Artyom Gil: I.M. Sechenov First Moscow State Medical University (**WHO Collaborating Centre on Training and Education of Health Policy-makers in Prevention and Control of NCDs**), Moscow

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Jürgen Rehm: Jürgen Rehm: served as a member of the **WHO Expert Committee on Substance Abuse**. Affiliations: Executive Director of the Institute for Mental Health Policy Research and Senior Scientist at the Campbell Family Mental Health Research Institute at the Centre for Addiction and Mental Health, a **World Health Organization/Pan-American Health Organization (WHO/PAHO) Collaborating Centre in Addiction and Mental Health since 1977**, in Toronto, Canada. He is Professor and the inaugural Chair of Addiction Policy at the Dalla Lana School of Public Health at the University of Toronto and Head of the Epidemiological Research Unit, Clinical Psychology and Psychotherapy at the Dresden University of Technology in Germany.

Yale School of Medicine

Department/Unit: *Program in Addiction*

Country/Location: United States of America

URL: <https://medicine.yale.edu/intmed/genmed/addictionmedicine/>

Submission

The tie-in to NCDs is supported.

Consider changing from substance abuse to substance misuse.

Consider listing the components of SAFER when the acronym is introduced.

Consider making an argument to funding entities and governments to consider aligning their health care spending priorities with alcohol interventions - decreasing adverse effects from alcohol on medical conditions such as alcohol-associated liver disease, cancer, and drink driving injuries are cost saving.

The focus on implementation of interventions that provide the highest return on investment is supported. Working with operations researchers and modelers, along with health economists can support this implementation.

Consider not only region specific interventions but also population (e.g. youth, HIV positive, etc) specific action plans. Not all populations have the same risk or experience the same levels of harm.

Pertaining to operational objectives, item 4: Consider targeted awareness as perhaps more efficient.

Action area 4, capacity building: Consider explicit recommendations and targets regarding healthcare workforce proficiencies and numbers.

Action area 1, the focus on implementation is supported. Consider adding strategies to de-implement ineffective interventions.

Consider highlighting other international abstinence efforts promoted by social media including "Dry January" - https://en.wikipedia.org/wiki/Dry_January

Consider addressing stigma in this document.

Action Area 5: Consider recommending more efficient use of data systems that are often in different silos. This would include but is not limited to linkage of criminal justice, health care, social services, pharmacy, death registries, emergency medical services and other datasets.

Yale Program in Addiction Medicine

Attachment(s): 0

Young Power in Social Action (YPSA)

Country/Location: Bangladesh

URL: www.ypsa.org

Submission

Our comments and suggestions are attached herewith for your kind consideration

Attachment(s): 1

00445_77_movendi-members-who-workingdoc-consultation-ypsa-bangladesh.pdf

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

YPSA (www.ypsa.org) is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

Young Power in Social Action (YPSA), an organization in Special Consultative Status with the United Nations Economic and Social Council (UN-ECOSOC), is a voluntary non-profit organization for sustainable development registered at Bangladesh contributing in national goals for making a difference in the lives of population since its establishment in 1985.

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.
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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.
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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.
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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
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 - Global action: WHO
 - National action: Member States
4. Implementation: formulate the operational principles + policy coherence
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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.

Youth against Alcoholism & Drug Dependency

Country/Location: Zimbabwe

URL: yadd.co.zw

Submission

Youth against Alcoholism & Drug Dependency is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*. Youth against Alcoholism & Drug Dependency is an NGO promoting healthy alternatives to alcohol, tobacco and drugs in Zimbabwe

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.

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A. 7 Points for Action Plan Improvement

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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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1. Role of the alcohol industry, conflict of interest

Attachment(s): 1

00492_16_who-workingdoc-consultation.pdf



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

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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 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.

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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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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.
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Youth for Development and Human Rights Advancement

Department/Unit: *Healty Department*

Country/Location: Rwanda

URL: www.ydhra.org

Submission

We raise awareness in order to reduce the amount of drugs and alcohol being consumed by youth in and out of schools

Attachment(s): 1

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

Youth for development and Human Rights Advancement Is grateful for the opportunity to comment on the working document to develop a global action plan to improve implementation of the WHO GAS*.

Youth for Development and Human Rights Advancement (YDHRA) is a local non-governmental Organisation Founded in 2015, we are focused on promoting human rights, Healthy and development among the youth and women which will finally lead to the development of our country and the world at large. We empower them to have a powerful voice, knowledge, and resources so as to create changed lives.

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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- 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.

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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.

ZERO SAF

Department/Unit: *FAMILIAS DE AFECTADOS POR SAF TEAF*

Country/Location: Spain

URL: zerosaf.es

Submission

La consideración más relevante es que el consumo de alcohol afecta directamente a quién lo consume y por tanto es su responsabilidad y hay que habilitar medios de ayuda para estas personas, excepto en un caso que es cuando quién consume alcohol es una madre embarazada. En este caso se produce un hecho inusual y gravísimo. Existen unas posibilidades altas de que se vea afectada una tercera persona, el bebe y que el daño que se va a producir sea para toda la vida y sin tener ninguna culpa del comportamiento inadecuado de la madre. Este niñ@ tendrá un daño cerebral conocido como SAF/TEAF dependiendo del tipo de afectación, pero que le supondrá de por vida tener muchas dificultades académicas y sociales. Es muy importante que la sociedad tome conciencia que durante el embarazo ZERO ALCOHOL .

Se calcula que un 3 a 4 % de nuestra sociedad puede estar afectado por este trastorno que impide que estos niños se desarrollen con normalidad porque nuestros Gobiernos no ponen los medios necesarios para acometer ayudas que puedan facilitar a estos chicos tener una vida adulta digna. Si no acometemos con urgencia reformas encaminadas a eliminar de la vida de las embarazadas el alcohol nos encontraremos en pocos años con una juventud con peores condiciones para sobrevivir en un mundo tan complejo como el actual. La vida de nuestros hijos esta en juego, las mujeres beben cada vez más, incluso que los hombres en algunos países, pero desconocen todavía el daño que pueden causar a sus hijos y conociendo a las mujeres en cuanto sean consciente de ello, ellas mismas solucionarán el problema.

Attachment(s): 1

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