

REPORT ON THE WHO REGIONAL TECHNICAL CONSULTATION ON A GLOBAL STRATEGY TO REDUCE HARMFUL USE OF ALCOHOL

WHO Regional Office, Brazzaville, Congo, 3-5 March 2009

INTRODUCTION

Opening session

Dr Therese Agossou, Regional Adviser on Mental Health and Substance Abuse, WHO welcomed participants and Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse, Department of Mental Health and Substance Abuse from WHO HQ in Geneva to the WHO Technical Regional Consultation with Member States. Dr Poznyak informed participants that this was the second in a series of technical consultations planned for all six WHO regions to consult and collaborate with Member States on a strategy to reduce harmful use of alcohol as mandated by the World Health Assembly in May 2008. The first regional technical consultation was in South East Asia.

Dr. Poznyak reminded participants that harmful use of alcohol is a global public health problem and that more attention is being paid to the relationship between harmful use of alcohol and diseases like HIV/AIDS and tuberculosis and also to broad social development issues. As a result, demands by Member States on the WHO Secretariat to provide guidance and technical support on evidence-based interventions to reduce harmful use of alcohol have increased in recent years. He stressed the importance of the consultation and the need to bring forward best practices that take into account differences in the social and cultural contexts. He thanked all participants for finding time to be present in Brazzaville and their governments for releasing them to attend the consultation. A welcome address by Dr Luis Sambo, WHO Regional Director (delivered by Dr Diarra, Director of Non-Communicable Diseases) welcomed delegates to the regional

headquarters of WHO in Africa. He told delegates that the burden of non-communicable diseases (NCDs) due to psychoactive substances was increasing in the region. In particular, the negative health and social impact of alcohol is pervasive and includes loss of income, health inequalities, intentional and unintentional injuries, violent crimes, neuropsychiatric disorders and poverty. In recent years, there has been growing recognition of the link between harmful use of alcohol and HIV/AIDS and tuberculosis in the African region. These problems, he said, are exacerbated by a pattern of consumption characterized by heavy episodic drinking and widespread consumption of beverages produced in the informal sector. WHO has drawn the attention of Member States to the growing evidence of a high level of burden attributable to harmful use of alcohol and the lack of appropriate national responses to these problems. Dr Sambo expressed his confidence in the capacity of Member States in the region to contribute to a reduction in harmful use of alcohol and related problems, through active engagement in the process leading to a global strategy.

Dr Agossou invited participants to introduce themselves by stating their names, countries, affiliations and their role in efforts to reduce the harm associated with alcohol in their countries. Delegates from 42 of the 46 Member States in the region were present at the technical consultation. (Annex 1). Facilitators from WHO/HQ, AFRO and the consultation secretariat also introduced themselves. Mrs Carina Ferreira-Borges of the WHO/AFRO introduced the Chair of the Consultation for day one, Mr Joseph W. Geebro, Deputy Minister for Social Welfare in Liberia. The consultation was chaired by Dr Djamila Nadir from Alge-

ria on day two and on the third day by Mme Yvonne Kayiteshonga of Rwanda.

BACKGROUND AND CONTEXT OF THE REGIONAL CONSULTATION

Dr Poznyak presented the background and context of the consultation. He said that an estimated 2.3 million people died of alcohol related causes globally in 2002, and in 2004 alcohol accounted for 3.7% mortality and 4.4% of disability adjusted life years (DALYs). He traced the history of World Health Assembly resolutions dealing with alcohol, beginning from 1979 to the 2005 resolution on the “Public health consequences of harmful use of alcohol”, and the actions and processes leading to the 2008 resolution calling for the development of a global strategy.

Dr Poznyak outlined the aspects of the resolution that calls for actions by Member States and the Director General of WHO. The resolution urges Member States to collaborate with the Secretariat in developing a draft global strategy on harmful use of alcohol based on all evidence and best practices, in order to support and complement public health policies in Member States. The resolution also calls on Member States to develop national systems for monitoring alcohol consumption, its consequences and policy responses and to consider strengthening national responses to reduce alcohol-related harm.

The resolution requests the WHO Director-General to ensure that a draft global strategy will include a set of proposed measures recommended for States to implement at the national level and details of ongoing and emerging regional processes. The Director-General is requested to collaborate and consult with Member States, as well as consult with inter-governmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol and to submit to the Sixty-third World Health Assembly, through the Executive Board, a draft global strategy to reduce harmful use of alco-

hol. Dr Poznyak reported on plans and progress in implementing the resolution, which involves a two stage process. Stage One consists of the following consultative activities:

- Web-based consultation (WHO public hearings) with the public at large, Member States and other stakeholders on ways of reducing harmful use of alcohol (3-31 October 2008, extended till 15 November 2008)
- Consultation with economic operators on ways they could contribute to reducing harmful use of alcohol (6 November 2008)
- Consultation with NGOs and health professionals on ways they could contribute to reducing harmful use of alcohol (24-25 November 2008).
- Consultation with intergovernmental organizations (planned for mid-2009)

Stage two of the process involves the development of a draft strategy. The following activities have been planned or are currently being implemented:

- Regional technical consultations with Member States (February – May 2009) in 6 WHO regions
- Draft development of a global strategy by the Secretariat in collaboration and consultation with Member States (May – October 2009)
- Translation and submission of a draft global strategy to the Executive Board (November-December 2009)
- Revision, if necessary, in consultation and collaboration with Member States, and submission to the Sixty-third World Health Assembly

Mr Dag Rekke, Technical Officer, Department of Mental Health and Substance Abuse, WHO-HQ, provided additional information on the web-based consultation in which responses were received from 340 individuals and organizations in 63 countries, and the two roundtable meetings with economic operators

and NGOs and health professionals. Mr Rekve introduced the discussion paper 'Towards a global strategy to reduce harmful use of alcohol'. He reminded delegates that this was the background document for the consultation process and that it was prepared as a guide for the various discussions.

OBJECTIVES AND SCOPE OF THE MEETING

Mrs Ferreira-Borges presented the aims and objectives of the consultation as outlined in the discussion document. The proposed structure of the draft strategy was presented.

- Background with a situational analysis
- Scope and aims of a global strategy, including 4 proposed objectives
- Basic principles for action
- Policy options and 10 priority target areas
- Implementation considerations
- Follow-up (e.g. assessment and re-examination of the actions taken)

She also presented a brief overview of the programme and methods of work for the consultation meeting. The main method of work at the consultation was discussion in groups. Delegates were divided into four groups, two working in English and two in French. Each group session started with a short introduction in plenary. The groups appointed a chair and a rapporteur and the secretariat provided guidance on how to lead and report back from the discussions. At the end of each group meeting, the rapporteur presented a summary of the group discussion at a plenary session.

SITUATIONAL ANALYSIS

Mr Rekve addressed the importance of understanding the current situation in various countries. The purpose of the situational analysis is to describe the size and magnitude of chronic and acute alcohol-attributable health

and social harms and to map existing best practices. Mr Rekve added that the analysis will build on the views and information provided by Member States in the regional technical consultations, as well as on the wealth of technical and political information that is already available. Delegates from most of the countries present took the floor to address the challenges that require global attention based on their national experiences. The major themes that emerged were:

a. Lack of awareness of the dangers posed by alcohol

There is need for education of the public, religious and community leaders about alcohol and the dangers posed by harmful consumption. Specifically a call was made for a day to be devoted to alcohol, as it is the case with tobacco and illicit drugs.

b. From legislation to practice

Legislations aimed at controlling the risks and dangers associated with harmful use of alcohol exist, but there are problems in their implementation. This is a challenge in many Member States participating in the consultation.

c. Multi-sectoral approach

Such an approach should involve the private sector, professional associations, civil society, the informal sector, traditional healers, political and community leaders. Specific attention should be paid to the development of public-private partnerships.

e. Capacity building in all areas of work related to alcohol problems

This could include formal training with award of diplomas.

f. Preventive measures

Attention to prevention is lacking but needed. Efforts in this area should take into consideration different avenues of response and integrated with other programmes at all levels

of the health care system, in both rural and urban areas.

g. Data and the knowledge base

Data are lacking on mortality, morbidity, and social problems associated with alcohol. There is need to link consumption to problems (i.e., establish cause and effect relationships).

h. Widespread availability and consumption of traditional/informal sector beverages

A greater understanding of the level of consumption and associated danger is needed. In addition, it is important to develop alternative means of income for producers of these beverages.

i. Role of the industry in the availability and consumption of alcoholic beverages

It is important to make a clear distinction between the social responsibility of industry players and their marketing strategies.

j. The role of WHO

Several of the delegates called on WHO/HQ and AFRO to help mobilize technical and financial support for work on alcohol, to help countries produce health promotion materials and to help develop political will in these countries.

SCOPE, AIMS AND OBJECTIVES OF THE GLOBAL STRATEGY

Dr Poznyak presented the proposed scope, aims and objectives of a draft global strategy. Discussions on these issues took place in the working groups and were reported back to plenary. The groups agreed that the scope of the strategy needed to be expanded to include other social development issues. Specifically it was suggested that the role of alcohol should be emphasized in the achievement of the Millennium Development Goals (MDGs) and in poverty reduction. One group suggested the issue of accessibility to vulnerable groups,

in particular children and women should be included. Some groups said that recognition of alcohol as a social problem even in communities where it is prohibited, taking into account cultural and religious values, should be included. There is a pressing need in the African region for capacity building and mutual understanding of the harm of alcohol in public health by the whole community in order to broaden the involvement of society. Suggested additions to the overall aims of the strategy are to include other policy areas relevant to public health polices such as development issues, legislation and socio-economic policies. A further addition is to have elements of Member State governments working together at the international level to address the multinational alcohol business.

Objective 1: One group proposed a change to expand public health policies to policies that include promotion, prevention, treatment and rehabilitation. Another group suggested a separation of objective one into two objectives – to mobilize support for development of public health and other developmental policies in regard to harmful use of alcohol; and, to provide guidance for the development of public health policies and other relevant policies.

Objective 3: Suggested changes would read identify and define stakeholders and their roles and responsibilities in concerted action to reduce harmful use of alcohol at all levels, global, regional and national.

Objective 4: An addition is the word application of information.

Objective 5: A proposed new objective is to have WHO provide additional support for countries without alcohol policies.

GUIDING PRINCIPLES

The groups suggested a number of changes and two additions to the guiding principles.

Principle 3: to add social and economic context.

Principle 6: (new) Policies and principles should give special emphasis to the protection of adult vulnerable groups such as pregnant mothers, mentally ill and physically challenged.

Principle 7: to read ; appropriate and effective preventive, treatment, rehabilitation and care services should be available, accessible and affordable for those affected by harmful use of alcohol and other substances

Principle 9: (new) Health promotion should be taken as a key strategy in reducing harmful use of alcohol and other substances.

POLICY OPTIONS

Ten proposed policy areas were outlined:

1. Raising awareness and political commitment
2. Health sector response
3. Community action
4. Drink–driving policies
5. Addressing availability of alcohol
6. Addressing the marketing of alcohol beverages
7. Pricing policies
8. Harm reduction
9. Reducing the public health impact of illegal and informal alcohol
10. Monitoring and surveillance

A short plenary session was undertaken where various policy options were presented and explained. The discussions were informed by concerns over how a global strategy can contribute to the utilization of these policy options in different countries. Delegates were asked to present and discuss best practices, evidence of effectiveness, and the role of different contexts. The groups discussed the experiences from their own countries, possible best practices that can be transferred to other settings and how a global strategy can complement and support the national level in the relevant areas. What follows are a summary of the specific suggestions made under each of the policy options.

RAISING AWARENESS AND POLITICAL COMMITMENT

Participants called for education of the public, religious and community leaders about alcohol and the dangers posed by harmful con-

sumption. At the national level, the creation of a multisectoral committee could provide a forum for engagement with political and public figures and various stakeholders (health professionals and NGOs). It was suggested warning labels should be placed on alcohol containers as a best practice and as a basic right to information.

Participants called for a world alcohol day, as is the case with tobacco and illicit drugs. A global strategy should integrate alcohol in different programmes, including those targeting non–communicable disease and communicable diseases. A suggestion by one group is to have alcohol issues on the agenda of regional bodies such as SADC, ECOWAS where regular reports on alcohol use and related problems and best practices are presented. A global strategy could help build capacity in all areas of work related to alcohol problems.

HEALTH SECTOR RESPONSE

The groups suggested that attention to prevention is lacking but is needed. Efforts in this area should take into consideration different avenues of responses and integrate with other programmes at all levels of the health care system, in both rural and urban areas. All groups endorsed the practice of EIBI (early identification and brief intervention) in health settings but stressed the need to strengthen skills to manage alcohol problems at all levels of the health care system. Participants suggested more emphasis on prevention and health promotion, while also addressing the treatment needs of those already affected by alcohol use disorders. A global strategy could provide the tools and the specialized infrastructures needed to manage alcohol–related problems.

COMMUNITY ACTION

Participants called for a multi–sectoral approach in community action. Such an approach could involve professional associations, civil society, the informal sector, traditional healers, political and community leaders and the private sector. Specific attention could be paid to the development of public–private partner-

ships. Using community resources to prevent alcohol problems is viewed as an example of best practice. Local community action could involve the community and young people in problem identification, planning, implementing and in policy enforcement. A suggestion is to show that everyone is vulnerable to alcohol problems. Community action could also establish and reinforce links to community associations (NGO, networks such as AA).

DRINK—DRIVING

Participants stressed the importance of the enforcement of existing drink driving laws, especially at festivals. Some groups suggested the use of road blocks for sobriety tests and the provision of rest areas for drivers with risky blood alcohol levels. The groups recommend the promotion and use of breathalyzers as an effective drink driving countermeasure. As part of the global strategy, WHO could help countries define minimum levels for BAC with the basic principle ‘the lower the limit the better’, in terms of reducing acute health and social problems. A strategy could develop tool kits for key people engaged in the prevention of alcohol-related problems. Surveillance and monitoring of road accidents was emphasized as a central part of policy.

ADDRESSING THE AVAILABILITY OF ALCOHOL

Participants said legislation aimed at controlling the risks and dangers associated with harmful use of alcohol exist in many Member States. However, there are problems in the implementation of the legislation. All groups endorsed well-known strategies to reduce exposure to alcohol, e.g., reduced drinking hours, licensing of outlets, sale to underage drinkers. Most participants endorsed the age limit of 18 years (which is already operational in many African countries). Some participants suggested a higher age limit of 21 years, considering that in some countries 21 year-olds are still under the care of parents. It was suggested that the distinction be made between selling alcohol to an underage person and using such a person

to sell alcohol considering the implication of this in cultures where underage children are used in the sale of different products. Stricter regulation of the informal sector was stressed as well as licensing traditional outlets. It was suggested that to reduce availability and exposure, there should be alternative non-alcoholic beverages wherever alcohol is sold. At the point of sale in supermarkets, alcoholic beverages should not be displayed together with water and other non-alcoholic drinks. The need for transnational control mechanisms was also recommended.

ADDRESSING THE MARKETING OF ALCOHOL BEVERAGES

There was general agreement for a total ban on alcohol advertising in all media (as is the case in some countries) and in social activities (such as sports) and in other communication channels. Some groups proposed restrictions on sponsorship. Industry self-regulation is not seen to be an effective strategy in dealing with alcohol related problems. Participants suggested harmonization of cross border alcohol marketing should be examined for the control of consumption and problems.

PRICING POLICIES

There is strong support for increased taxation. Tax rates should be based on alcohol content, with spirits attracting a higher tax. However, while there is evidence that high prices can lead to reduced consumption, it could also result in changes in drinking pattern with negative health and social impact. For example, high prices for commercial beverages can result in increased consumption of dangerous beverages from the informal sector. Regular review of prices in relation to level of inflation is suggested. Money accruing from taxation could be diverted to treatment of alcohol problems.

HARM REDUCTION

Participants said there is no systematic approach to harm reduction in the region and little evidence is available on those measures

that have been implemented. Participants recommended a ban on “alcopops” and the sale of spirits in small packets in order to protect young people. Harm reduction measures should be considered during festivals, given the widespread practice of heavy drinking during these events and its consequent harm. However, harm reduction should not replace restrictions on the consumption of alcohol during these festivals. Alcohol sales to intoxicated persons should also be prohibited as a harm reduction measure. Designated driver or “rent a driver” programmes could be an option. Alcohol should be sold and served in unbreakable containers to avoid harm from breakable bottles.

ILLEGAL AND INFORMAL ALCOHOL

Participants agreed that much remains to be known regarding informal alcohol, both in terms of level of consumption and associated problems. A global strategy could support research in this area to provide the necessary evidence. The groups suggested that most forms of informal alcoholic beverages produced in African countries are considered to be fairly safe, but that contamination clearly exists and occasionally groups of consumers have been poisoned from contaminated drinks. Some form of quality controls are needed such as licensing and training of producers. In addition, it is important to raise awareness in the general population and among consumers about the dangers inherent in the consumption of some forms of beverages, as well as the enforcement of existing laws on the production and consumption of these beverages.

MONITORING AND REPORTING

The development of national monitoring systems in the region, and reporting the progress made in achieving the aims of a global strategy at different levels of implementation was seen as a central requirement. Participants in all groups emphasized the need for good data to support policy formulation and implementation. While delegates called on governments and the international community to provide funding for regular data collection activi-

ties in every country, they also recognized that opportunities already exist in ongoing exercises which can be expanded to include alcohol data. For example, programmes in the health care sector, such as on reproductive health, could be used to collect needed data on drinking in the population.

Participants recommended the establishment of national substance abuse data collection systems with sub-national networks. Such a system could benefit from existing regional programmes by WHO (Global Information on Alcohol and Health) and the UNODC (biennial survey on drugs) as well as HIV and NCD surveillance. A few key alcohol indicators with direct relevance to national policy priorities (poisoning, drink-driving, recorded consumption, liver cirrhosis) could be identified and integrated into existing national data systems. Regular reporting and sharing of findings was also stressed by the working groups.

While complete data on consumption, harm and effectiveness policy may not be available, other political and cultural considerations were seen as important in guiding the direction of alcohol policy. A sense of urgency was expressed as it is clear from the country experiences that harmful use of alcohol is a major health and social problem in the Region.

IMPLEMENTATION CONSIDERATIONS

TOOLS TO HELP IMPLEMENTATION

Participants suggested several tools for effective implementation of the strategy. The majority of tools identified are for capacity building such as guidance on policy formulation and implementation, training manuals, best practices, fund raising and advocacy tools, regulations and standards for manufacturing products and a guide for governments on how to deal with industry interests. Surveillance, monitoring and reporting tools are also mentioned. The tools specifically suggested were:

- An implementation guide on each policy option,

- Surveillance and monitoring package,
- Reporting tools,
- Standard training manuals,
- Rapid situation analysis tool,
- Tools for standards and regulations for manufacturing processes and products,
- Fund raising and advocacy tools (In this regard it was suggested that WHO with support from member states should raise funds for the implementation of the strategy).
- Guidance package on the steps to be taken in the process of policy formulation and implementation
- List of resources available,
- List of best practices that can be shared internationally or regionally,
- Tool kits for supporting young people and vulnerable groups,
- Tools that can address alcohol problems in special groups like refugees, war areas etc.,
- Guide for governments on how to deal with industry interests,
- Tool for the media.

STAKEHOLDERS

Participants recognized that the development and implementation of an effective alcohol policy is a multi-stakeholder process. At the national level, participants said the Ministry of Health should take the lead in policy, strategy development and implementation, and in advocacy. Other ministries (e.g., Tourism, Internal Security, Justice, Social Welfare, etc) should participate as part of a multi-sectoral response to harmful use of alcohol, advocacy and financing. Non-governmental organizations (NGOs) could assist in the formulation and implementation of policy, advocacy, and also participate in prevention, treatment and care. Economic operators have a role to play in the implementation of the strategy and in providing information for the assessment, but not in the formulation of policies. Research institutes can conduct research and provide the evidence base for policy decisions.

Professional associations should engage in advocacy and implementation of the strategy.

Media could play an advocacy role and promote awareness of the problems and best practices. Community leaders can play an important role in advocacy and social mobilization in local communities. At the international level, UN bodies (UNICEF and WHO and WHO, UNDP, UNFPA, UNHCR, UNODC) could provide technical and financial support, and participate in advocacy. Regional and sub-regional bodies (IGAD, SADC, AU, COMESA, ECOWAS) could engage in addressing cross border issues and in mobilizing political commitment. Participants urged WHO to take a technical leadership role in global efforts towards the reduction of harmful use of alcohol, at all levels.

DIFFERENT CONTEXTS

The discussion focused on the relevance of different cultural, religious, economic, and development contexts in the implementation of a global alcohol policy. Participants recognized differences in the Region and agreed that a global strategy should take into consideration not just the religious and cultural contexts but also the availability of resources, the level of the problem, and the capabilities that exist in each country. A number of suggestions were made on how national differences could inform effective alcohol policy. Initial efforts could be directed at collating existing data from a variety of sources as they exist in each country. Efforts to work with all key informants and custodians of culture and to seek their involvement in the implementation of policy would add understanding to the contextual issues. The global strategy could highlight mechanisms of assistance for countries with limited resource and capabilities. The strategy can learn from successful approaches to other public health problems that require special consideration of contexts, e.g., ongoing programmes for the control of HIV/AIDS, malaria, and polio. Obstacles to the successful implementation of alcohol policy, for example corruption, should be addressed through the multi-sectoral and regional collaborations and with global support. Mrs Ferreira-Borges said that the main regional challenges for the implementation

of alcohol policies in the Region are a greater awareness, support and consensus around policy options within Member States and in the Region for public health policies that address harmful use of alcohol. There is also a need to develop and implement effective alcohol control policies and to improve surveillance and enforcement measures in countries. She said that regional initiatives such as capacity building for health professionals and technical support and guidance to countries for the development and implementation of evidence based policies are already underway.

CLOSING SESSION

In his closing remarks, Dr Poznyak expressed gratitude from the Secretariat and reminded delegates of the central role the Region has already played in the process leading up to the resolution calling for a global strategy on alcohol. Specifically, the initiative came from two

countries in the Region – Kenya and Rwanda. He expressed satisfaction with the outcome of the consultation and briefed delegates on the next stages, which will involve consultations in other WHO Regions, production of a draft strategy and consultations with Member States on the draft strategy. The draft will then be published on the WHO website as part of the documentation to the Executive Board in January 2010 and, if approved, sent to the Assembly for consideration in May. Dr. Diarra, DNC, on behalf of the Regional Director, thanked all delegates for their participation in the meeting. She reminded them that WHO/AFRO had started discussions in the African Region in 2006 on harmful use of alcohol. In 2007, the regional office held its first ever discussion on the topic with ministers from Member States, who then called on WHO to present a draft regional strategy in 2008. Dr Diarra said this was the beginning of a long process and thanked everyone for their participation in the process of developing a global alcohol strategy.